

A faint, light blue background illustration of a large, multi-story building, likely a hospital, situated on a hill overlooking a river. The building has a complex roofline with multiple gables and chimneys. In the foreground, there is a bridge or walkway crossing the river, and a small figure of a person can be seen walking on it. The overall scene is depicted in a soft, painterly style.

HOSPITAL ON THE AVON

F. O. Bennett

HOSPITAL ON THE AVON

PEOPLE from every walk of life have been associated with Christchurch Hospital over the past hundred years, and in these pages their sense of duty, their triumphs, their difficulties—and their weaknesses—are sympathetically recalled.

The surgeons and physicians who laid the foundations of a great tradition of service are remembered, the idiosyncrasies of many being amusingly recounted. The story of the evolution of the nursing profession is particularly interesting, with its emphasis on the devotion shown by the individual nurse under the trying restrictions on personal freedom common to the age. The resourceful orderly who had his own 'medical practice' on the side is not forgotten, while the chapter dealing with the hardiness and tribulations of the patient is revealing, and at times poignant. This chapter alone will enhance one's gratitude for the skills of the medical profession today.

The author has traced with scrupulous care the growth of the service provided by the Hospital from its slender, inadequate beginnings. Nothing has been overlooked.

This book is not one for a relatively small group of people. It is of immense appeal to all.



HOSPITAL ON THE AVON

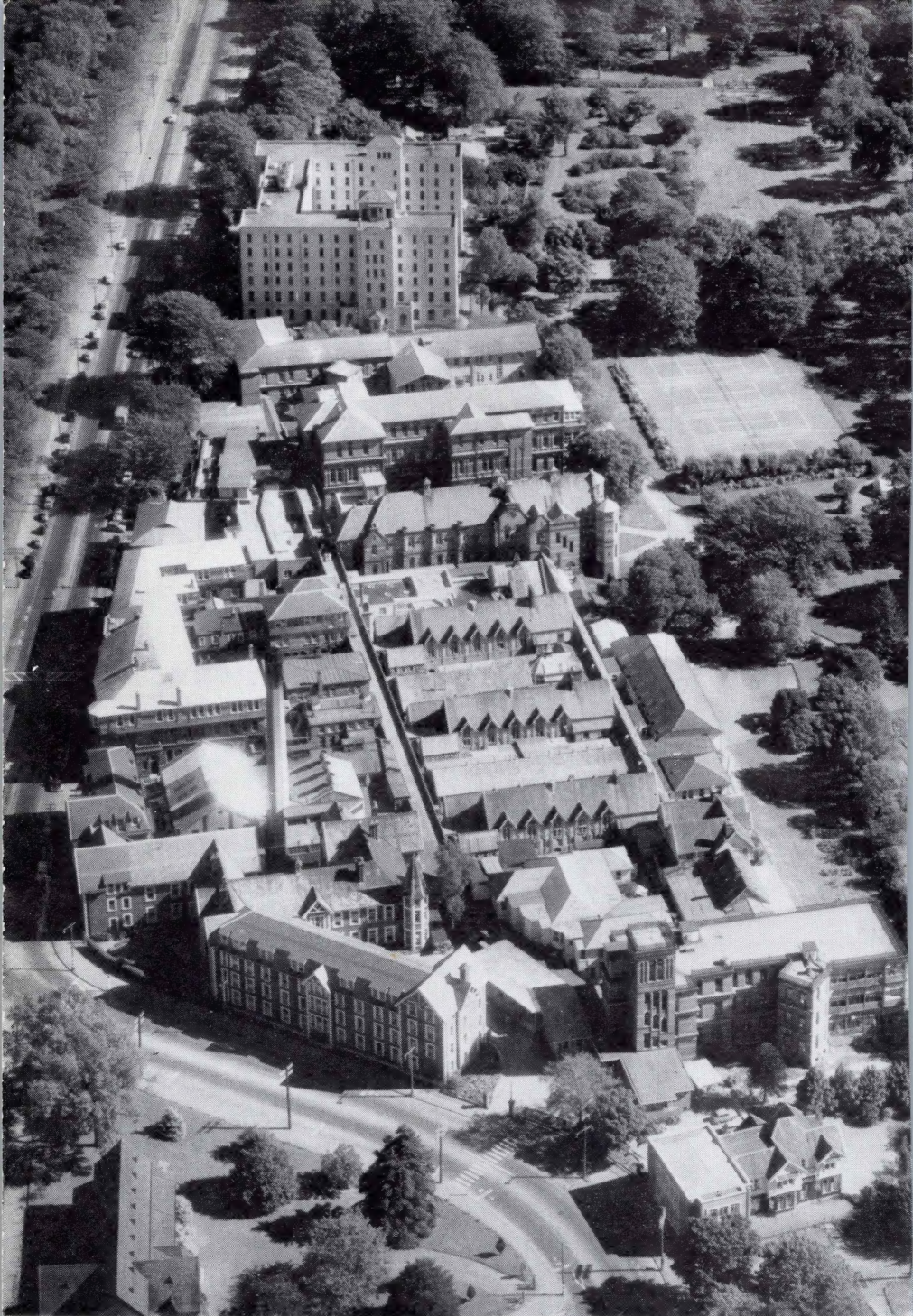


Photo: V. C. Browne

CHRISTCHURCH HOSPITAL TODAY




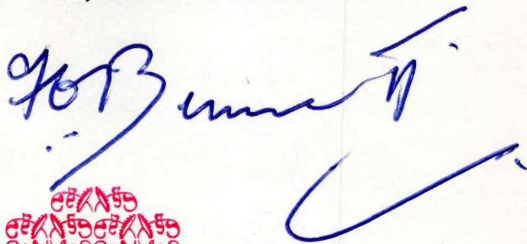
HOSPITAL ON THE AVON

The History of the Christchurch Hospital
1862 - 1962

by

F. O. BENNETT

CONSULTING PHYSICIAN, CHRISTCHURCH HOSPITAL



NORTH CANTERBURY HOSPITAL BOARD
CHRISTCHURCH
1962

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Introduction

IN THE YEAR 1950, THE CENTENNIAL YEAR OF CANTERBURY, it was proposed by Mr J. Leslie Will at one meeting of the Hospital Visiting Staff that the hospital developments of a century merited record in historical form. The staff immediately reacted with sympathy and a subcommittee composed of Mr Will, Mr D. Macmillan, Mr L. A. Bennett and the present writer was appointed to consider details.

This led inevitably to a consideration of past histories of which at the time there were two. In 1925 Dr P. C. Fenwick had produced his *History of the Christchurch Hospital*. This was a small volume, limited in scope and material. Miss Winifred Norris's *Fragments of History* produced in 1942 was largely a chronological list of events recorded without comment. (A third history, limited to three copies, was to be produced in 1954 when one copy was presented to Her Majesty on the occasion of the Royal visit to the hospital. It was mainly pictorial and its sixteen pages of print was no serious contribution to hospital history.)

The first decision made therefore was that a new history was required with a completely different approach. The second was that in order to avoid a conflict of emphasis it should be the product of one pen and not a symposium by a committee. The present writer was approved by the subcommittee and later by the visiting staff. The whole matter was then laid before the Board which welcomed the idea and promised all assistance.

Then began the search for material and the more difficult this became the more it emphasised the necessity for such a history. The initial problem was to know where to look and a later one to know what to select. A final problem was to observe the disciplines of accuracy and of space and to reject

the dramatic if unreliable and to reject the reliable if unimportant.

Sources of reference have been so multiple and their interpretation so dependent on wide reading, sometimes on marginal subjects, that an itemised bibliography is impossible. An important source has been all the records held by the North Canterbury Hospital Board since 1879. (Earlier records were lost in Wellington.) Valuable information has come from the publications of the Canterbury Provincial Government, the early newspapers, the historical records in the basement of the Lands and Deeds Survey Registry, private letters of the early colonists and the many published books on local history.

All this would have been inadequate without a great deal of help from many persons. A major contribution has been made by Mr David Macmillan who has supplemented his *Highways and Byways of Medicine* with many pages of additional notes. Miss Norris's history was a frequent source of reference and was found to be invariably accurate. Mr G. R. Macdonald of West Eyreton supplied biographical details of some of the early doctors.

Wherever possible senior officers of the hospital have read the manuscripts relating to their own departments and have offered constructive criticism though they are not necessarily responsible for the views expressed. Past and present members of the staff have frequently contributed details or amplified memories of the later years. This group cannot be dismissed without grateful acknowledgment of the help from the Board's secretaries (Mr A. Prentice, Mr J. G. Laurenson and Mr D. Horne) and also from Mrs Chambers (Lady Superintendent), Sister A. C. Fleming (household staff), Dr J. F. Landreth, Mr J. L. Will, Dr T. Morton, Mr L. A. Bennett, Mr A. Wilson (engineering department), Mr W. A. Miller (former head porter), Mr A. R. Gavan (splint department), Mr V. Fargher (office staff), Mr F. T. Hogsden (central store), Mr K. A. Donaldson (photographic department), and the late Dr William Irving.

The City Council, the Health Department, the Turnbull Library, the Lands and Deeds Registry, the Museum Library and the Public Library (especially Mr R. C. Lamb of the

research department) have all willingly co-operated from their resources.

Finally, there have been innumerable items of information by word, letter or telephone from many well wishers among the public. These fragments, often small in their content, have been impressive in the mass and at times important in their value.

The history of the hospital includes of necessity a history of the Hospital Board and therefore of the institutions it controls which number twenty three. It involves also the complicated story of charitable aid and the welfare of the orphans and the aged. A manuscript dealing with all this was prepared but its formidable bulk precluded publication in a single volume. From it the present history was compiled leaving material which may form the basis of two subsequent volumes, the whole to form a review of the medico-social evolution of Canterbury.

The author is deeply indebted not only to all those mentioned but also to the North Canterbury Hospital Board which has commissioned this work, has assisted with encouragement, clerical help and finance and has undertaken the mechanics of publication.

Throughout the text certain features are consistent. For instance though an appraisal of a person's work may have been made after his death or retirement this is avoided as far as possible when dealing with contemporaries. Degrees and qualifications, especially of doctors, are rarely recorded. In the present they are not necessarily permanent and in the past they were often not available and sometimes were disputed. The amounts of various expenditures are usually given to the nearest pound. In locating certain areas on the hospital premises the assumption is made that the long corridor runs east and west and the wards north and south. This is not strictly accurate geographically but will serve for descriptive purposes.

April 1962

*The further backward you can look the further forward
are you likely to see.*

SIR WINSTON CHURCHILL

CHAPTER ONE

67/129

A Strange looking Building

THE CHRISTCHURCH HOSPITAL IS ON AN ISLAND CRUSHED between river and road. In a century it has developed a facade which belies its form for in its depths it is compressed into a jumble of stone, brick and wood, shapeless with a confusion of architectural postscripts and makeshifts. It is the frontier of a main highway and for years the quiet of the sick place has been shattered by the grinding of the traffic round the corner. It has shut up its beautiful gardens and closed its front door. Around it are the green grasslands but they are incidental to the setting and do not belong.

Yet it has a heart that beats. Its work is excellent, its organisation smooth, its control effective and its staff loyal. It presents the paradox of a poor machine doing good work. As it stands at present it is the product of a century of bold thought and timid compromise, of opportunities taken or missed, of the consequences of victories and defeats in many personal and political battles, of something that has never been comprehensively planned but yet through ceaseless persistence of men and women has arrived.

The long story follows.

The decision to build a hospital in the new colony was made in England in 1849. It was a pure policy decision as barren of public enthusiasm as the inauguration of income tax. The young colonist, venturing into a new life, imagined himself crossing many horizons of adventure before age or mischance halted him with the practical problems of death or disease. Yet the decision, having been made at an authoritative level, had to have some material form and so the equipment for a hos-

pital was carried on the *Charlotte Jane*. An inventory given by one passenger lists it as a hospital chest, a cholera chest, beds and bed pans, night shirts and other essentials. The only clue to the last item is given by Capt. Thomas who later complained that his living quarters had also to accommodate the dirty hospital linen.

In Lyttelton despite the stimulus of available beds and bed pans the hospital apathy persisted. Two sections in turn were selected as a site and in turn abandoned as unsuitable. In November 1851 the home of the Rev. O. Mathias was rented for £40 a year, the equipment was moved in, the six beds occupied and the province of Canterbury had its first hospital. Two years later it was vacated (overcrowded, no offices, roof leaking, mental patients wrecking the place). The old customs house building was then equipped as a hospital and persisted for nine years as such, (short staffed, overcrowded, dilapidated, referred to officially as 'hopelessly bad', 'wretched hovel', sold at auction along with site for £32). Then in 1863 Lyttelton got a hospital, built as such, a grand new building in Dampiers Bay with six wards and three nurses. Six years later it was closed (unpopular, few patients, high administrative costs and superfluous to the new Christchurch hospital of 1862). The Lyttelton hospital became the Canterbury Orphanage Asylum which is another story and a grim one redeemed only by the honest justice with which it was burnt down in 1909 leaving the Hospital Board to the present day with a confusion of sections, landslides, retaining walls and a reluctance to agree with the Lyttelton Borough Council on the responsibility for maintaining roadways.

The later hospital history of Lyttelton has been marked by courage, pertinacity and a sense of responsibility. But when the Christchurch Hospital was built it could not borrow any fragment of a blue print of perfection from the hospitals of Lyttelton, nor anywhere else in the colony. In 1846 Captain Grey (later Sir George Grey) had secured grants for hospitals at Auckland, Wellington, Wanganui and Taranaki. They were primarily for the Maori and the indigent white, but during the Maori wars they were also used for military cases supplemented by tented hospitals at times, nearer the scene of action.

By any modern standard they were miserable structures, and yet, like most medical establishments in the face of crisis, they had a good record. (When in 1864 Queen Victoria visited the Royal Victoria Hospital at Netley she was shown twenty soldiers wounded in the New Zealand wars. Three had had a limb amputated, six had had joint resections and one had been shot through the lungs. It was in the same year that the Queen conferred the Victoria Cross on two Assistant Surgeons, W. G. N. Manley and W. Temple for bravery in action during the Maori Wars.)

Neither the claims of war nor of Maoris could be used as an argument for building hospitals in the South Island. Dunedin built its first in 1851. Christchurch had to wait till 1862. It would have been built later still had not public pressure triumphed over official reluctance. The reluctance was partly due to the fact that of all possible public enterprises a hospital would pay the least dividends. It could never be an investment; it had always to be an expense. As in England the rich could endure their illnesses at home where the resources were just as great. The poor were in a different category, but the community was easily irritated by the poor, more so if sick. The welfare of the weaklings had a very low priority among the pioneering projects. When the Society of Canterbury Colonists was formed in London, the members discussed prices, land, education, religion, banking, birds and animals and shrubs from Kew. They christened the unborn city 'Christchurch', (show of hands—eighteen for, eight against—carried). On May 9 1850 they were addressed by Dr Ramsay of Gloucester on the subject 'Medical and sanitary provision necessary for a newly formed community'. He was thanked heartily, assured that he must come back and address them again (sometime) and was then shown out and never heard of again in the records. On his departure the meeting settled down to discuss the vastly more important subject of land tenures.

Another reason for the apathy regarding hospitals was the suspicion that they could offer little for the sick. There was some truth in this. There was no one in the new colony able to conceive of anything better than the English hospital and

even the great teaching hospitals of England were poor things where the governors were primarily concerned with economy of maintenance. The medical staff practising in such hospitals on an honorary basis were yet there at the indulgence of the lay authorities and were in no state to become rebels of reform. The doctors reserved their interests to the strictly scientific aspects of their work. Between the money and the medicine came the patient, morally inarticulate because he was usually the object of charitable aid.

Under such circumstances it was easy to argue that a hospital was a poor asset. Yet the hospitals had to come and the deciding factor was not treatment but accommodation. Domiciliary treatment with all its crude simplicities was possible for those who had a home. But there was the case of the man who took ill in a hotel and had to be nursed in hurried spasms by a reluctant chambermaid, the immigrant who lived in a hut by himself, the servant who became an invalid, the accident case who arrived from the country in a dray, the acute mania, the sick person brought ashore from a passing vessel at Lyttelton. These in the early years were disposed of in various ways but in every case one or more private individuals had to shoulder public responsibility. Sickness put a premium on voluntary aid until voluntary aid, fatigued and conscious of inadequacies, became the mouthpiece of public opinion and demanded a communal effort in the form of a hospital.

The Provincial Government had anticipated this and at an early stage had reserved a site for a hospital at the corner of Durham and Armagh Streets. This was the first step in a planned procedure for the intention was to proceed wisely, build carefully and not soil the future with the fingerprints of haste. The hospital in short was to be an adjunct of the medical school, which in turn was to be part of the activities of Christ's College. This academic ideal began to lose touch with reality when in 1858 the Provincial Government took over the site and built the Provincial Chambers on it, claiming that the site was too small for a hospital. In his address at the opening of the first session in the new chambers the Superintendent (Mr W. S. Moorhouse) possibly spoke with a slight sense of contrition when he said 'I shall have to recommend the establish-

ment of an institution very much required, viz—a hospital at Christchurch for the reception and treatment of sick persons’.

The council adopted the recommendation and brought down, two months later, the ‘Public Hospital Endowment Bill’. It dealt exclusively with finance. It empowered the Superintendent to sell certain reserves to raise the £1500 to build a hospital. His Honour had made his recommendation on October 1 1858. By December 3 of the same year the Bill had passed all its stages, received his Honour’s assent and was despatched to the Governor-General in Auckland for the supposed formality of his approval.

But what was considered to be a medical necessity in Canterbury was considered to be a political misdemeanour in Auckland. The Colonial Government was against selling reserves. The main purpose of creating a reserve was to prevent its sale. To sell a reserve in New Zealand was like selling Hagley Park. The Governor-General refused to approve the Bill. But the subject was kept alive at the provincial level. A Monsieur Kloer, proprietor of a travelling hippodrome, gave a benefit performance and the proceeds (£19) was the first contribution to a hospital building fund. A long letter in the *Lyttelton Times*, wordy and sentimental and signed by Mr Fred Thomson, urged the necessity of a hospital. Lone campaigners in the cause began to shift their persuasions from the public to the politicians and within a year the hospital project began to gain momentum. In October of 1859 a memorandum was laid before his Honour the Superintendent praying for the erection of a hospital. It had 275 signatures and included ‘all the principal residents of Christchurch’. The energetic Provincial Secretary, Mr J. Ollivier, presented it and even seemed to have anticipated it because at the same time he laid on the table of the House the Christchurch Public Hospital Bill. The Council went to work on it.

The Bill sought to define the site, the finance and the control. The site selected was the present one in Hagley Park and this immediately put the Bill in the greatest danger. The initial protests soon swelled to a full throated chorus of ‘Hands off Hagley Park’. Hagley Park was only a paddock with a creek in it but the word ‘park’ implied secret potentialities. Less

probably would have been heard of it if the area had been known as 'the Hagley Reserve'. The Bill passed the first and second readings with increasing difficulty. The third reading was preceded by a public meeting at which the Christchurch citizens were numerous, noisy and more or less dedicated to dying on the banks of the Avon in preference to allowing the enemy a foothold in Hagley Park. They had a simple slogan. Throw the Bill out. Let the Government purchase a site—not filch public reserves. There was a quality to the word 'filch' which confirmed the impression that something sinister was afoot.

The Council however was less susceptible to this emotional appeal and in the Council Chambers Mr Ollivier ably put the Government's point of view. The site was suitable in that it was so close to town. ('Here, ladies who are accustomed to charitable offices could visit the patients') and much to be preferred to the suggested alternative site of four and a half acres on Kerr's Sandhills run (near Burwood). The area (over five acres) would provide suitable gardens for convalescents and would prevent a repetition of the mistake committed in Lyttelton where the only place for the convalescents was a wooden form in the public street. The site was healthy, it was too small to be used for other purposes, it could not be built upon, and altogether it was an obvious selection.

Others agreed. Mr Blakiston particularly liked its proximity to the town and added 'no one surely would propose that the hospital be established at a distance so as to render it necessary that broken limbs and suffering bodies should be carried over an extent of rough country, swampy sandhills and tussocks'. Mr Cass also approved and was very pleased that the site was on the flat. If it had been on a hill there would have been an excuse for abstaining from visits of charity. He had been told by the Bishop of New Zealand never to build a church on a hill—all the asthmatics would seize on the excuse and stay away. He thought that in England there was a certain charm in meeting patients from nearby hospitals in Greenwich Park, St James's Park, Hyde Park and Green Park. He had no patience with those who objected to the site as the

majority of them had no idea where it was and had not taken the trouble to go and see.

It was left to Mr Packer to lead the opposition, and he would have served his cause better had he been more temperate. He said the park had been set aside as a lung for the town. The Government should purchase a site. They did not need five acres. They wanted a hospital not a palace. Five acres was outrageous but all the Government's views were large. At Home many hospitals were built on one acre. It had been claimed that five acres would provide a pleasant and airy place for convalescent patients to walk about. He hoped that when these gentlemen were well enough to walk they would walk off.

Mr Packer had a special tilt at the Provincial Secretary, Mr Ollivier, a fluent speaker, who had said in his final peroration, 'What is Christchurch? What is Canterbury? When Christchurch fills and expands what then? What would posterity say if they found the hospital built round and enclosed in the town?' 'The province will grow,' replied Mr Packer, 'but when it does there will be more hospitals. Posterity! What do I care for posterity? What will posterity know about me? The question is one for the present day; let posterity look after itself.'

The debate focussed finally on the amendment that the government be asked to purchase another site. Ten voted for it, eleven against, the Bill passed its third reading on October 20 1859 and by this flick of fate of one vote the hospital with all its consequent problems of restriction was destined to its present site.

Even at the present time one cannot help wondering at the fact that five acres, one rood and thirty-two perches should have been stripped off Hagley Park for a public utility. Christchurch citizens have always been fierce in their defence of Hagley Park. In the early days various attempts to erect in Hagley Park a Maori hostel, Inwood's mill, a cattle market were all lost. An attempt by the City Council in 1949 to erect an instrument shed in the park was frustrated by a solid wall of public opposition, much of it deriving from the hospital. And when in 1961 the Board discussed a nurses' swimming

pool the Council was quick to declare that no new portion of the park was available as a site.

The unfortunate effect of the conflict over the site was that the hospital itself was viewed by many with disfavour. A large section of the community was angry about it. In 1868 the *Lyttelton Times* in a leader warned against encroachments on Hagley Park and cited the hospital as one. 'It had been intended originally to form the Botanical Gardens on that site and no better one could have been found for the purpose. The presence of a stream of water, an undulating surface and excellent soil afforded all that could be desired. On the opposite side of the river lies the Government Domain, of a light sandy soil, peculiarly suitable for the erection of a hospital or sanitary establishment. But on this sandy soil hundreds or rather thousands of pounds have been spent in the difficult attempt to produce an ornamental effect.'

The decision on the site automatically meant that there was to be a hospital and the other clauses in the Bill were now examined. The capital cost was to be provided by the Provincial Government. Maintenance was to be ensured by fees collected and by public subscriptions as in the great teaching hospitals of England. This either betokened a deep ignorance of the past traditions of the English hospitals, of their endowments, bequests, and of their dependence on a teeming population or else it represented a naive confidence in the future of New Zealand. It was apparently based on the commendable assumption that what prospered in London must prosper even more so in Canterbury.

Equally impracticable was the method of control. As a liaison between the Government which owned the hospital and the House Surgeon who worked it there was to be a Board of Trustees. These comprised his Honour the Superintendent, the Provincial Judge, the Anglican Bishop, members of the Executive Council ex-officio and five lay members. The last were to be elected by and from those who had contributed £5 or more to the hospital funds.

Having thus settled the problems of site, control, cost and maintenance the Government was then forced to defer indefinitely the erection of the hospital. The first depression of

the province intervened. The estimates for the year were inadequate and men were put off public works. The labour market was flooded and wages fell from eight shillings a day to five. Public meetings were held and attempts were made to stop immigration. The politicians were not prepared to take bold measures in the face of financial stringency and political unrest. Even though the conditions that prevented the hospital made it more necessary it was the wrong time to embark on fresh outlay. During the third reading of the Hospital Bill Mr Cass had pointed out that in the previous session the Government had approved of £3000 for a Supreme Court and £10,000 for churches and schools but had not yet raised the money. To these ghosts that lacked material form was now added that of the hospital and for the time being the blue prints of them all were stored away in some otherwise empty coffer.

A temporary expedient was then tried. A circular signed by his Honour (Mr W. S. Moorhouse), Mr Justice Gresson and Mr E. C. Bowen drew attention to the need for a hospital especially for station owners who were forced to send their sick servants to lodging houses and appealed for funds to rent a house that could be modified as a hospital. The resulting contributions varied from £1 to £10 and totalled £123. Public liberality had recently been exhausted by an appeal for the Taranaki victims of the Maori war and there was no surge of sympathy for station owners who wanted a makeshift hospital. The suggested public meeting never eventuated nor did its object. What happened to the money is not known. It was probably returned to the donors.

The depression began to lift in 1861. The Bill of 1859 was brought out, dusted and studied. The Christchurch Hospital Ordinance was passed which gave the Government power to build and the authority to control a hospital. It instructed its architects, Messrs Mountfort and Luck, to prepare plans. In March of that year tenders were called. That of J. Dobson for £1150 was first accepted but later cancelled in favour of J. Ferguson whose figure was £1756. As the contract contained the usual penalty clauses for delay it was not long before the Christchurch Hospital began to take shape and form.

There was neither sentiment nor ceremony about the erect-

ion. It had no grip on the public imagination as had the Cathedral. No foundation stone was laid. Only two references can be traced in the *Lyttelton Times* to its progress. On January 4 1862 is a comment on 'the hospital, nearly finished, (a large building near the Scottish Church)'. Three months later there is a vigorous editorial on the unsatisfactory state of the town's sanitation and the subject is introduced thus:

'There is a strange looking building with excrescences like feelers stretching towards the road on the Avon at the Hagley Park end of the town. This is the new hospital and it is said to be curiously incommodious inside. The drainage of this is so arranged as to have an outfall into the river!'

On June 1 1862 the hospital was opened. There was no ceremony. Apparently the staff went in as the builders went out. Eleven days later the newspaper reported on an inquest on a young man (Frank French) who died in the hospital.

It is impossible to escape the conviction that the hospital was regarded generally as a utility, a necessity worth fighting for, but not an institution deserving of any public pride. In those vigorous days it could hardly be otherwise. As a building it was preceded by the Provincial Chambers, by St Andrew's, St Michael's and Avonside Churches, by the Bank of New Zealand and the Union Bank of Australia, by theatres, hotels, post office and gaol. There were reading rooms at Lyttelton and Christchurch and three newspapers in the province, Christ's College was flourishing and Anderson's foundry, Reece's hardware and the firms of both Ballantyne's and Beath's had been established. The first railway in New Zealand from Christchurch to Ferrymead and the first telegraph in Canterbury were nearly completed and about to be opened. As an institution the hospital followed the Canterbury Jockey Club, the Horticultural Society, the A. and P. Association, the Musical Society, the Masonic Lodge, the Christchurch Municipal Council and the Brass Band. Rangiora was a township and Christchurch had a town hall.

The early disparaging comments on the hospital had some justification for it was an ugly building in a barren setting. The architects had given no thought to making it harmonise

with the landscape. Admittedly they had little scope in a landscape so drab.

The city did not extend further west than about the Cashel Street bridge. Oxford Terrace, an unpaved dusty or muddy road with no efficient footpaths or drainage, curved rather sharply at the Durham Street corner and ran straight towards the open country where is now Addington. On the right it sloped down to the weed grown banks of the dirty Avon. On the left were a few scattered buildings as well as the most prominent landmark in the vicinity, a square based windmill in Antigua Street which was then known as Windmill Road. One redeeming feature was the pleasing design of St Andrew's Church, then a veteran of five years' standing. Between the present Provincial Council Chambers and the hospital there were tussock lined roads rather than formed streets and perhaps a dozen houses—often the three roomed lean-to type all equipped with the standard outhouse. There were a few shrubs round the houses but no trees. Hagley Park was only another bare paddock. A distant ridge against the background of the Alps was Deans bush.

The hospital area was a pinched off corner beyond the river. It was tussock grown, unfenced and, when the workmen had finished with it, a sea of mud. The hospital itself was erected roughly on the site of the present Chalmers block. Past the front door, parallel with the Avon, ran the famous stream known as 'the Creek' though for many years it was a sewer.

No part of the original hospital now survives, though some of the earliest additions do. The few existing photographs were taken from below the level of the building down near the bank of the Avon and give a distorted view of the whole structure which probably had more shape and form than the photographs suggest. These show a two storeyed building parallel with and facing the Avon with a central buttress running at right angles down towards the river. The northern portion had an ornate projecting porch with gables and dormer windows which was the official entrance; this was in marked contrast to the severe austerity of the rest.

The construction materials were timber on stone foundation, weatherboard outside and plastered inside. Ventilating air

grates were provided in the skirtings and under the ceilings in the walls, and also 'on Arnott's principle' connected with the chimney flues. Each room had its open fireplace. There was a total of eight wards, two of them being partially detached for infectious cases. The dimensions in feet were:

21 x 15 x 9 (4 beds)	19 x 19 x 9 (6 beds)
14 x 11 x 9 (3 beds)	20 x 15 x 10 (4 beds)
20 x 15 x 12 (6 beds)	36 x 17 x 9 (12 beds)
24 x 19 x 12 (9 beds)	36 x 18 x 9 (12 beds)

This information is contained in a letter from the Provincial Secretary to the Colonial Secretary in response to the latter's request for information about the new hospital. It confirms evidence from other sources that the hospital after all was only a house and little thought had been given to its peculiar needs. The eight wards were in fact eight rooms. Kitchen, dispensary, living quarters and all the services had somehow to compete with patients for space. Within two years there was talk of building an entirely new hospital.

The architects who planned and the politicians who built had no specialised knowledge nor even an awareness that such was required. They were ignorant of the functions of a hospital and thought of it merely as a building. Equally blameworthy were the doctors for their tacit acquiescence. They were vocal enough with less reason at later stages. The first doctor in Christchurch was Dr Barker, ex-surgeon of the *Charlotte Jane*. He practised for a few years in Christchurch but his heart was not in medicine, let alone hospitals, and he eventually retired because of a weak back and devoted himself to land speculation and to photography in both of which he was extraordinarily successful. (Dr Barker was a pessimist of gloomy outlook. In one of his many letters to his brother in which he prophesied bankruptcy owing to his multiple commitments he commented, 'Among other things I have a perfectly useless section of sixty acres on Papanui Road'). The first Superintendent, Dr Stedman, was said to have taken much interest in the building of the hospital. He was a quiet gentlemanly ophthalmologist, highly respected but not dynamic enough to fight out an economic issue with politicians.

Such were the origins of the Christchurch Hospital. Once erected it was clearly visible from the Council Chambers, but the Council was not proud of it and voted £500 for planting a screen of trees in Hagley Park.

CHAPTER TWO

22/29

Problems of Control

THE STAFF WAS APPOINTED BY THE GOVERNMENT. DR SILAS K. Stedman M.D. was physician and Dr Burrell Parkerson was surgeon. They were joint superintendents. This arrangement, unique in the medical history of Canterbury, seems the more extraordinary in that for a time it appeared to work. Their salaries were £300 a year each. Mr and Mrs Bunting were master and matron respectively and were paid jointly £120 a year, Mr Dalglish was resident dispenser. There were also two nurses, a laundry maid and a porter.

The Government pushed on, anxious to be quit of the hospital business. Equipment was provided on a domestic scale with the addition of some drugs and dressings. The Rev. Henry Torlesse was appointed chaplain to hospital, asylum and gaol. Fees for patients were set at thirty shillings a week and no patient was admitted until he had signed a statement guaranteeing the fees (one third of the patients signed with a mark). The staff was advised to practise the strictest economy. Having done this the Government washed its hands of the hospital, leaving the staff to do whatever it was that staffs should do to patients. It was confident that the hospital would run on its own momentum; it did not know that the smooth running of a hospital depends on an enlightened authority controlling an harmonious staff working among co-operative patients in adequate premises on a sound budget. Every one of these requirements was missing from the first hospital.

Much of the earliest criticism was directed against the architects. Even before the hospital was finished Dr Stedman pointed out that there was no deadhouse, no operating room

and that the kitchen was inadequate. (The Lyttelton Hospital built the following year had the same omissions.) He complained of the health hazard from the smoke of the fires. So the kitchen was extended and for the first time he was consulted as to where the chimney should be placed. He declined the offer stating that it was an architectural matter not a medical one. Before the first year was finished he had filled the two fever wards and wanted two more with a covered way. In 1864 the Government voted £839 for repairs, alterations and minor additions including a deadhouse. A fortnight after the contract was signed Dr Stedman wrote indignantly to the Council pointing out that the contractor had not yet started and added:

‘If the autumnal fever should be as severe this year as last it will badly cripple the usefulness of the hospital to have the want of the additional buildings. The drainage of the hospital is in a disgracefully inefficient state.’

Later in the year another £545 was expended on further additions, mainly living quarters for the resident surgeon. The hospital had now a dispensary, a chapel, a Board room and an operating theatre. In 1865 Dr Stedman in his annual report referred almost confidently to new wards and suggested that they should be built on ‘the pavilion plan which is not only favourable to this country but will be added to as the colony progresses and the population increases.’ The new wards were built in 1867 by Mr D. Reese (£860), in the form of a new wing attached to the east end near the Oxford Terrace entrance. On the ground floor was an inquest room (20 x 11) and a combined operating, consulting and lecture room (16½ x 15½). Upstairs was a male ward (24 x 24) match lined with tongue and grooved timber; this was to persist for many years as the dreary Ward 1. These additions completely altered the appearance of the hospital and obliterated the original design. It is doubtful if this was all pure gain for in the same year it was reported that ‘The fever wards have given way during the late stormy nights’. In the first five years the Government had spent on additions far more than the original hospital had cost.

It is impossible to record in pictorial or diagrammatic form the two building contracts of 1864. They were apparently additions at the rear of the hospital and no photographs or detailed descriptions can be traced. The extension in 1867 is well shown in photographs.

The original staff was no more stable than the original hospital. While the curious dual control by the two doctors persisted, letters went to the Government complaining of inadequate space, small domestic staff, low pay for nurses, chairs for convalescents, absence of facilities. Sometimes the letters were signed by either, sometimes by both. At the end of a year Dr Stedman was appointed to sole charge with what was then a very generous salary of £900 a year. His duties however included not only the hospital but the asylum, the immigration barracks, the gaol, the police department, and the charitable aid. In May 1864 he resigned in order to resume his ophthalmic practice in Armagh Street. Dr Parkerson who had continued as surgeon also resigned. Dr Downes became resident house surgeon, and it was decided to appoint a part time physician and a surgeon. Owing to the finances of the province they were expected to work in an honorary capacity until better times. Thus began the honorary system which was to continue almost unchanged for seventy-five years.

Even then the honorary positions were contested. Dr Prins was successful against Dr Nedwill for the surgical post (voting 58-43) and Dr Stedman defeated Dr Turnbull for the physician's appointment (voting 60-35).

Previous to this there had been other staff defections. Mr Bunting resigned as master after a few months but wished to live on at the hospital and pay board. The Government agreed and named the board whereupon Mr and Mrs Bunting, united in indignation, left. Mrs Harvey became matron. Within the first year Mr Dalglish resigned as dispenser and was succeeded by Mr W. R. Cooke. The one contented member of the staff seemed to be the porter who, according to the bylaws had a bewildering list of duties including attendance at all operations, keeping the deadhouse clean and being available for messages day and night, but who in fact did so little that he supplemented his annual salary of £60 by a thriving boot

repairing business on hospital premises. He survived for a few years till he was swept out on a wave of economy.

By the end of the first year the Government was far from satisfied with the hospital and its increasing demands. It had fathered an unruly child but was determined to find foster parents. It reverted to the original plan of a Board of Trustees and passed the Hospital Ordinance of 1863 which repealed the Christchurch Ordinance of 1862. By this later enactment the hospital and its site was transferred to the Board of Trustees, and the control was vested in a Board of Governors. The definition of a Governor was anyone who paid two guineas a year to the hospital or who preferred to be a Life Governor for thirty guineas. It was also possible to be a Life Governor by being nominated by a corporation which had paid thirty guineas for the privilege. A proclamation from the Superintendent ordained that for executive purposes a smaller committee of management was to be elected from the main body of Governors, and on February 2 1864 his Honour presided over the first meeting of Governors called for this purpose. Those selected were: The Ven. Archdeacon of Akaroa, Rev. O. Mathias (President), Mr Gould (Treasurer), Rev. H. Jacobs, Mr Justice Gresson, Mr C. Bowen, Mr A. C. Barker, Mr C. W. Bishop, Mr C. O. Torlesse, Mr R. Wilkin, Mr F. Thompson. Later when a secretary was appointed the choice fell on the ex-dispenser Mr Dalgleish. In changing his vocation Mr Dalgleish made the bitter comment that he wished to have no more to do with the doctors of Christchurch.

Most of the personnel of this committee were men of character and integrity, prominent in the development of the province. Yet as a committee they were utterly blind to the obligations of their office. They were dedicated to economy, respect for authority, prevention of abuse of privilege, and as far as can be gathered were never responsible for one positive act that might have contributed to the welfare of the patient.

For a time the committee met every Wednesday. Instead of going as a body into the hospital to see what was happening it spent its time drawing up bylaws to define what should happen. Most of these bylaws were restrictive; there were twenty four clauses too lengthy to detail. All the staff personnel had their

duties defined in terms of perfection. The main references to patients indicated that if they were vouched for by a Governor and if they would guarantee fees, and if the House Surgeon (and no other) was available to admit them they could get in, and they could also get out summarily if they drank, smoked, swore or played any game of chance. The hospital had to be locked at night and no-one could leave. A lighter touch was that all nurses had to be able to read and write. Once a week the Secretary and a Governor inspected the hospital and then in a special book filled in answers to nine specific questions as to whether all members of the staff were busy, sober, tidy and efficient, whether patients were appreciative and well behaved, whether there was any sign of waste. The staff were secretly questioned as to the conduct of the patients who in turn were privately invited to voice any complaint against the staff. If there was a shortage of beds first priority of admission went to the urgent cases, then to those who lived furthest away, then to those whose recommendation was made by the Governor who had made the fewest recommendations in the year and finally to those whose recommending Governor was the largest contributor to the hospital. At the same time measures were taken to see that beds were not to be swamped by medically or financially unsatisfactory patients. The committee decreed:

‘That no woman in an advanced state of pregnancy, or child under six years (except in cases of sudden accident), no person disordered in their senses or subject to epileptic fits or suspected to have small pox, venereal disease, itch or other infectious distempers, no persons having chronic ulcers on the legs, inoperable cancers or dropsies in their last stages, or those apprehended to be in a dying condition or incurable, shall be admitted; or if inadvertently admitted be suffered to continue.’ (The veto against dying patients was later withdrawn on the stern insistence of Dr Turnbull.)

It seems incredible that such a body should have thought that by deliberately excluding a large group for whom the hospital was built, by developing a spy system and treating the staff and patients as if they were inmates of a reformatory and

not an infirmary they should have aroused enough public enthusiasm to keep the supply of contributions flowing. Naturally the reverse was the case. The public became suspicious and mistrustful and subscriptions fell. Finances became chaotic. By 1864 the average number in hospital was forty and the average cost per patient was £2 a week. The *Lyttelton Times* stung the committee by pointing out that this could be explained only by mismanagement since the cost in the Dunedin Hospital was 17/- per week. The committee attempted to deflect the blame onto the inadequacies of the hospital. In a special report it said 'The accommodation of the present building is totally inadequate for the requirements of the public. The Board of Management requests the Board of Governors to apply to the Government for a sum of money to erect a new building which should form a part of the whole which may eventually supersede the present inconvenient structure and also to remodel the old building.' It elaborated the plans at some length and estimated that it would cost less than £4000. The Government treated this as nonsense and almost said so, but it was hurt at its hospital, aged two, being referred to as the old building. The committee then applied to the Government for a special grant to forestall a crisis. It was reluctantly given the minimum with a firm intimation that it was the last.

The committee was much more capable in matters of finance than in hospital control and it was quick to recognise an impossible balance sheet. The hospital was costing £4000 a year; against this was a precarious £308 in patients' fees and an even more precarious £200 in subscriptions. The future was so bleak that bankruptcy was preferable. It recorded a motion:

'The Governors of the Christchurch Hospital are desirous to surrender their trust into the hands of the Provincial Government and request the Government to release them from the responsibilities of the management of the Christchurch Hospital at their earliest convenience.'

No attempt was made to dissuade them. No eulogies were heaped on them. The next day the *Times* said 'Trembling and terror stricken the Governors of the Hospital have dropped their burden at the feet of the Government. The ostensible

reason for throwing up their trust is the fact that the hospital costs £4000 a year.'

The following week the Provincial Secretary called in the books, demanded the return of the surplus funds (16/7), and nominally the Government resumed control.

Not that the Government had any intention of retaining control. It was determined that the public hospital was going to be maintained by the public. If the public would not do it voluntarily then they would do it by compulsion. On August 18 1864, the Provincial Secretary, Mr William Rolleston, moved the following motion:

'That in the opinion of this Council the ordinary revenue of the Province ought not to provide funds for the maintenance of the hospital and other necessary charitable purposes. That it is desirable to provide such funds by means of a rate to be levied on all property throughout the Province, or the same may be assessed with ratepayers' rolls in the various road districts.'

The House approved the motion but not unanimously. Mr Ollivier deplored it. It was a reversion to the bad English system of rating for Poor Relief with workhouses and infirmaries attached. It was the very thing they had been trying to escape. In this he was quite correct but his argument would have been stronger if it had embraced a satisfactory alternative. The House was in the mood to stabilise the shifting insecurities of hospital control. It passed the Hospital and Charitable Aid Bill which came into force in October 1864. By this the cost of maintenance was guaranteed by rates. The internal management was the responsibility of the house surgeon who in turn was to answer to the Government. The house surgeon was Dr Downes who had just been appointed by the late Governors. This did not satisfy the Government which appointed Dr Prins, and this in turn did not satisfy Dr Downes.

Christchurch Hospital

20.9.1864

SIR,

In reply to your letter of the 19th wherein you order me to vacate the office of House Surgeon to the Hospital I beg

to state that I do not recognise the Canterbury Government as having any authority in the matter.

I was appointed House Surgeon for two years by the Governors of the Hospital and I shall require that the terms of the engagement shall be fulfilled.

I am, Sir,

Your obedient servant,

J. B. DOWNES

Nothing more is heard in the hospital of Dr Downes (which seems a pity) but much more is heard of Dr Prins who in addition to his administrative duties took over all the surgery. Dr Stedman remained as honorary (or consultant) physician. (He later contracted typhoid and died in hospital.)

With finance and staffing thus settled the Government turned its back on the hospital confident that it would now run smoothly. It was an enormous error. The doctors saw to that.

CHAPTER THREE



Down among the Doctors

THE EARLY DOCTORS OF CANTERBURY WERE A RUGGED LOT and had to be if they were to survive professionally. With the exception of the first doctor in Canterbury, the famous Dr Donald of Lyttelton, they had nearly all arrived as ship's surgeons. On arrival they weighed their chances and the majority moved on, often into the less turbulent waters of farming or commerce. The adventurous who elected the hazards of private practice had first to get registered. They presented their credentials to local magistrates who, if the candidates had a recognised university or medical school qualification, had no hesitation in issuing a certificate of registration as a medical practitioner under the Ordinance of the Provincial Council of New Munster, Session 1, May 1849. But if the alleged qualifications were obscure diplomas from obscure colleges, or doubtful testimonials from unknown persons, or the assertion of a deceased doctor that the applicant had served a satisfactory apprenticeship, the magistrate was in a quandary and was tempted to give the petitioner the benefit of the doubt. The other doctors were not always so charitable and some men practised most of their lives in Christchurch under a cloud of ostracism. The new doctor then set to work to attract a practice and could do so only by deflecting the loyalty of the patients of other doctors. Thereafter public approval automatically balanced professional hostility. He aimed at social success and affected fine horses, houses and habits for those were the days when everyone said that Jack was as good as his master and no one believed it. He advertised flagrantly, often having standing advertisements of half a column in the



The Christchurch Hospital when completed in 1862. The last of these buildings was demolished in 1917.



The hospital about 1870. The two high gabled structures on the left are the additions of 1867. The first was the residence of the porters. The second became part of wards 1 and 2.



Wards 1 and 2 after they had been modernised about 1886. Other items of interest are the creek, the bridge built from the timber of ward 3, St Andrews church, the fence, the gates and the bluegum.



The east end of the hospital between 1904 (when the house surgeon's residence was built) and 1917 (when wards 1 and 2 were demolished).



Fire in the roof of ward 8 (1908). The tankstands are also shown and behind them is ward 6 on the right and the theatre on the left (now part of the radiotherapy department).



Dr Walter Fox



The Matron, Miss R. Muir, laying the top brick of the present hospital chimney. Mr W. Harrop in attendance. (1919)



Nursing and medical staff of the hospital about 1880.



Nursing and medical staff of the hospital about 1890.

local paper. He published his testimonials, entered into business associations with chemists, and generally was prominent on local bodies and committees where, though his interest might be genuine, the resulting publicity was useful. One young doctor was warmly commended in the press for drawing the attention of the authorities to the fact that all the fire buckets on the Rakaia bridge were empty. The paper was unaware that he himself had emptied them. Another, trotting along Cambridge Terrace, saw a child floating down the Avon. He rode his horse into the stream, draped the child over his saddle, successfully applied artificial respiration, and restored the victim to the search party further upstream. The incident immediately focussed on him the approval of the town and the envy of his colleagues. They differed in training, qualifications, basic medical knowledge, nationality, philosophy, religion and ethics. Everything in their making had shaped them to be fierce individualists and they were loyal to their training. Only when there was any outside threat to their professional status did they close their ranks.

From this prickly group the Government had to staff the hospital. Some of them got on the staff for the sole purpose of being able to announce in the press shortly after that, owing to the pressure of private work, they had to resign. Domiciliary practice differed little from hospital practice in its details and in its effects the latter was a serious threat to the former. The Government, realising that the fewer doctors it had in the hospital arena the less fierce would be the conflict, tried to keep the staff low. In fact it preferred a staff of one, a house surgeon who would do all the surgery and also the administration. But this was not practical and some outside practitioners had to be appointed. For some years in the early stages these were called consultants which meant that they had no duties unless called on by the house surgeon. They were therefore unpaid and this effected the double purpose of economy and of limiting the competition for an appointment by making it unattractive. It was not happily accepted by the appointees. At that time the house surgeon was not necessarily excluded from private practice. He could operate or assist at an operation, appear at a consultation or even make the occasional domicil-

iary visit; the fees were his own. This trespassed on the territories of the consultants who when they in turn reciprocated by working in the hospital got no pay. Later, when the hospital grew and the consultants had to visit regularly, they became more insistent that they should be paid. The Provincial Government was sympathetic but was always short of money.

Dr Prins, the new house surgeon, was a man with wide interests including politics, music, horticulture and racing. He had been born in Ceylon, had studied in Calcutta and London and was undoubtedly an able surgeon. He lived on the site of the present City Council Chambers in Manchester street. For two years he was house surgeon and at the same time was medical officer to the gaol and the asylum and had the right of private practice. The Government approved of the economies he introduced but many of his colleagues were jealous of a practice so solidly based. Their criticisms eventually forced his resignation. The Government appointed Dr Vernon as house surgeon and almost immediately replaced him with Dr Powell (£250). Dr Prins became the visiting surgeon (£100), Dr Turnbull the visiting physician (£100) and Dr Coward was appointed to the outside institutions (£200). Temporarily the honorary system was abandoned though it was done only by splitting Dr Prins's salary among five people. Even this failed to please some of the critics. Dr Frankish persistently wrote to the papers claiming that Dr Prins had resigned from the hospital only and that his removal from the other positions was equivalent to dismissal. The Government replied that their policy was in line with that of the Imperial Government. Dr Frankish then attacked Dr Vernon, alleging that the latter's preference for enormous doses of chloride of lime in all his prescriptions proved that he was no doctor at all. Dr Vernon began his reply in the press—'Mr Frankish may have been fortunate enough to buy a St Andrews diploma, but—' Eventually the Hon. Wm Rolleston stopped the correspondence by stating that the appointments were going to stand and adding, 'I trust this new experiment may not be another failure in the history of Christchurch hospital.'

The Government's choice included men of considerable calibre. Dr Powell was an eye specialist, learned, gentlemanly

and respected. He was an M.R.C.S. and an M.D. of Heidelberg. His career had been brilliant despite the handicap of ill health. The Medico-Chirurgical Society was formed in 1865 at a meeting held in his house and he was the first secretary. His interests were not only in medicine but in science and philosophy and he was a recognised authority on the arachnidae.

A much more robust character was Dr Turnbull who may have believed in conciliation as a policy but had little practical experience of it. His positive views were the more emphatic because of his deep Scots brogue. He took considerable part in public life and was prominent in improving the water supply of the city, especially by developing the deep artesian system. He represented the City in the Provincial Council from 1862 till 1865 and was also on Christ's College Board of Governors, and a member of the Selwyn County Council. He was an M.D. of Guys and came to New Zealand in 1858. He was in partnership with Dr Hilson and they ran a druggist's shop on the corner of Armagh and Colombo streets which was later sold to Cook and Ross. In his generation he was known to all the town not only because of his personality but also because of his wooden leg, his clumping walk and his old hansom cab with the seat facing backwards. When Dr Hilson died suddenly Dr Turnbull intimated that he was stopping practice while certain rumours were circulating. The police then exhumed the body, proved that death was from natural causes and Dr Turnbull resumed.

Dr Coward was born in the year of Waterloo. He was first in partnership with Dr Fisher and later with Dr Powell. He succeeded Dr Donald as coroner and often had to defend himself against his colleagues for insisting that a post mortem examination should be done by someone other than the patient's doctor. Like Dr Powell he had wide interests and was treasurer of the Philosophical Institute. One of his sons, Sir Cecil Coward, became president of the Law Society in England. He died in 1888 at the age of 73.

For two years the new arrangement worked smoothly and then Dr Powell resigned and went to England. (On his return the following year he resumed his ophthalmological practice

but was also science master at Christ's College and for a time was lecturer on chemistry, biology and zoology at the Canterbury College Union. He was secretary of the Acclimatisation Society and president of the Philosophical Institute. He died in 1879 at the age of forty seven.) Dr W. E. Phillips became house surgeon for six months and he in turn was followed by Dr Burrell Parkerson junior. This is the only occasion in the history of the hospital when father and son have been house surgeons in the sense of being Superintendents. It is probable that neither was very happy in the position. The father was a tall gloomy looking man with a strong Norfolk accent. He had no affectations and described himself as 'only an old family doctor'. Yet he was very highly respected and when he resigned and left for England in 1864 he was given a public address presented by Judge Gresson.

The son, like the father, was tall and dour, was an enthusiastic cricketer and along with his brothers was interested in farming. His interest was less in surgery and he thus controlled the hospital mainly as an administrator. This meant that the clinical work devolved on the visiting surgeon and physician who, when bound to the theatre, could not deal with any emergency among the fifty patients in the wards. Repeated requests were made for more staff. The Government's reply to this was to stop the salaries of the staff it did have. The honorary system thus came back, this time to persist.

The profession protested of course but had to admit that times were bad and economy essential. But, they claimed, the staff could now be indefinitely expanded as no money was involved. Even this the Government resisted for fear that such staff might ever revert to a stipendiary basis again. The doctors then more or less took the matter into their own hands and called on any willing outside colleague to deal with a hospital emergency.

The Government could not ignore this and in 1870 appointed a select committee of the House to enquire into the whole matter of hospital staffing. The report advised two surgeons, two physicians, an ophthalmic surgeon, a pathologist and a house surgeon. The Government could see no justification for the pathologist but approved the rest. There was no defined

term of office and consequently the staff was always changing and it is impossible to ascertain who held the actual appointments at any one time.

In 1874 the staff was Drs Nedwill, Turnbull, Frankish, D. Campbell and Powell. They presented a petition asking that they should be paid for their services. The Government was sympathetic but nothing further was done. In 1875 Dr Parkerson died in hospital of typhoid and for six years there was an endless search for an efficient house surgeon. Dr Donald was asked if he could procure one from an immigrant ship. He was not successful and the energetic Dr Campbell took over the hospital, sleeping in the institution every night. This lasted for twenty five days for which the Government paid him two guineas a day. Dr Campbell's appointment even though it was for less than a month was a personal triumph as it removed the shadow of a cloud. Some time before he had been attending a dying patient one of whose final acts was to write a cheque for £500 in Dr Campbell's favour. There was much criticism of this and allegations of undue influence. The whole affair became public property when, after the death of the patient, the bank refused to accept the signature and Dr Campbell sued the trustees. In consequence the Government had asked Dr Campbell to resign his honorary position on the staff. A return to official favour was indicated by his appointment as house surgeon and later by his re-appointment on the honorary staff, and finally by the very genuine sorrow at his tragic death. (See later.)

Dr Guthrie then became house surgeon for a few months until Dr Robinson replaced him. In less than a year he had been succeeded by Dr J. S. Hayes of Kaiapoi who held the position for five months.

In 1875 the Government terminated all the appointments of the honorary staff but re-appointed them as consultants. This presumably was a tactical precaution over the matter of salaries. The only objection came from Dr Prins who refused to serve further. He said that harmony was essential in hospital work and he was tired of the bickering on the hospital staff. After some persuasion from the Superintendent he relented.

Then came the fateful year of 1876. Coincident with the

departure of Dr Hayes the Provincial Government ceased to function and authority passed to Wellington. Almost the last act of the Superintendent was to ask Drs Guthrie, Nedwill and Powell to act as house surgeons in rotation. They agreed though Dr Guthrie held the position for most of the time. Mr Rolleston himself as chairman of the Selwyn County Council and member of the House of Representatives acted as liaison with the Government, and by the authority of the Government issued in 1877 new regulations for the control of the hospital.

This curious organisation worked for two years. The various house surgeons, particularly Dr Guthrie, made many requests and suggestions but they all had to go to Wellington and they were rarely granted. At one stage Dr Guthrie asked Mr Rolleston for authority to effect minor repairs in an emergency. He cited the broken gas mantle at the gate and the blocked water rams. The reply was that such actions would be approved but he should follow them up with a requisition in the ordinary way.

But remote control from Wellington was unsatisfactory and something of a more domestic nature was required. And so, on March 4 1878 the Christchurch Hospital got its first Board. It was not however a hospital Board. The gazette notice intimated that it was a Medical Board and would comprise Drs Turnbull, Deamer, Doyle, Frankish, Hay, Nedwill and Powell. Later in the year Drs Prins and Symes were added. This was perhaps the most naive of all schemes in the history of the hospital. The personnel of the Board included some on the staff and others who would like to be on the staff. Close friends and bitter enemies sat side by side. They had little authority and less supervision. They were issued with a minute book but kept no minutes, and later when the Government demanded the return of the book it could not be found. It was impossible for such a body to contribute to the progress of the hospital. This was all the more lamentable because the hospital, as will be seen shortly, was rapidly extending. Wards 4 and 5 had been built and Ward 6 was under way. Almost the only effective thing done by the Medical Board was to sign its own death warrant by asking the Government to appoint a lay Board to control domestic and administrative matters.

The Government reacted to this quickly, so quickly that one wonders whether the appointment of the Medical Board had not been a subtle scheme to prove that it was impossible for medical men to work harmoniously. Whatever the design the first Hospital and Charitable Aid Board was established in December 1878 and by so doing automatically cancelled the Medical Board. Its personnel was the Mayor of Christchurch (Mr H. Thomson), the Mayor of Sydenham (Mr G. Booth), Mr J. E. Brown and Dr Turnbull. All the members were Government nominees and there was no election by the citizens of Christchurch. The purpose was plain. The function of this Board was to blunt the growing autocracy of the staff and eventually to replace it.

It was a formidable task and could have been approached either in a spirit of sweet reasonableness or by a heavy direct attack. The Board chose the latter and almost immediately the war was on. For a start the Board was hard pressed. It was held responsible for the tensions that followed its inauguration and comparisons were made with the alleged serenity of the previous two years when, to use a phrase popular with the staff, 'the doctors ran the hospital themselves'. The public were inclined to share this view, insisting that there should be no taxation without representation and that a Board merely appointed and not elected was an imposition. The Board itself, utterly inexperienced, completely lacking in diplomacy, felt that it could manipulate the internal dissensions of the staff for its own purposes but soon found that it had instead created a brotherhood of resistance within the hospital. Even Dr Turnbull who was chairman of the staff and a member of the Board, and whose personality was such that he would never be happy in sitting on any fence, threw in his weight with the staff.

Five months after the Board's appointment the question of authority became so confused that the Board appealed to the Colonial Secretary who paid a visit and immediately came into conflict with Dr Turnbull. 'The staff,' said Dr Turnbull, 'would not permit any other medical man to enter within the walls of the hospital, that they would fight the Government, the Board, and the public in the matter.' The Colonial Secretary asked 'Do I understand Dr Turnbull to say that he con-

siders the present staff to have an exclusive right to the hospital?' Dr Turnbull, 'Yes'. There was more from Dr Turnbull—that the staff had been appointed for life on good behaviour; that the Board had no authority to make appointments, it never having been gazetted, that the staff would accept no appointments under the Board; and 'much more to the same purpose'. The Colonial Secretary listened, nodded sympathetically to the Board and went back to Wellington where he put through a formal gazette notice appointing the Board. Encouraged, the Board passed a motion (seven months after its inception) advising the Colonial Secretary to cancel all the appointments of the staff and call for new applications for the ensuing year. The staff, less belligerent and also less confident than Dr Turnbull, got in first and asked the Government to cancel their appointments. The Government, more concerned with the result than the method, agreed, and the way was now open for the Board to call for new applications.

By this time it was apparent that behind all the accusations and recriminations was a stern struggle between a lay Board and a professional staff for hospital control. Though not recognised at the time it was history in the making. The Board backed by the Government was determined to resist an oligarchy by a privileged class. The staff, feeling that the responsibility of professional work necessitated professional freedom, decided that it would boycott all hospital appointments while the present Board persisted. The Board relied on public opinion. The staff relied on 'the solidarity of the profession'. Both were, and always have been, creaky structures.

The Board then called for applications for the hospital appointments. Its apparent confidence was tempered by a sense of caution that made it announce that a staff of three would be adequate. It knew, as did everyone else, that three were too few but this number was determined by necessity rather than by preference.

The applications closed. The Board met to consider them and with gratification viewed the eleven sealed envelopes on the table all marked 'Tender for Hospital Staff'. The boycott had failed. The Board decided to press home its victory and, before opening the envelopes, discussed the desirable size of

the staff. The ideal it decided would not be three but five. The envelopes were then opened. Five contained valid applications. Six contained blank sheets of paper.

The five were appointed and four of them resigned immediately refusing to work with Dr Campbell because of his previous ethical breach. The Board called for further applications and received two—Dr Townend and Dr Chilton. It appointed Dr Townend only. Dr Chilton's failure was due to the fact that Dr Chilton was in disgrace. One of the first acts of the new Board had been to appoint Dr Mark as house surgeon. Little is known of him except that as soon as he arrived at the hospital and inspected it he committed suicide. The Board tried to cover this awkward incident by hastily appointing Dr Chilton who though he stayed longer was still not a success. The substance of a secret Board discussion became known to Dr Chilton and thereby ceased to be secret. He was summoned before the Board and asked to divulge his sources of information. He named two Board members. One of these accused him of lying and the other of breaking a confidence.

It was not a very good show all round but Dr Chilton could see that the writing was on the wall and would shortly be in the minute book. He hurriedly resigned and wrote to the staff (the five new appointees four of whom were soon to defect) for a frank opinion on his work. They replied in terms that carefully avoided all offence to anybody. The Board 'received' their letter and announced defiantly that 'appropriate measures' would be taken for securing a new house surgeon.

These measures were not very spectacular. The Board proposed to get a more satisfactory resident surgeon by raising the salary from £250 to £500. But the Colonial Government thought the bribe too high and refused. The position was advertised but no one was interested in a job where the Board was difficult, the staff was hostile and the pay was poor.

As the boycott by the profession seemed absolute (so absolute that Dr Turnbull refused to attend meetings of the Board and also refused to resign) the Board began to consider the non medical members of its staff. In 1873 Mr and Mrs Pridgeon had become dispenser and matron. Mr Pridgeon had been a veterinary surgeon at Prebbleton. There is considerable

evidence that he was a person of character and worth. The Board began to consider him as a possible house surgeon and asked the opinion of its acquiescent staff which approved. Thereupon Mr Pridgeon, the dispenser, was formally appointed Resident Surgeon.

The appointment was a little less extraordinary than it would be now. The bylaws in 1865 stated 'The Dispenser shall walk the hospital every morning and evening with the Resident Surgeon. He shall also be responsible for dispensing all medicine, noting diets and extras, weighing and measuring all stores, keeping the books and assisting in discipline.' The appointment lasted for six months during which period no criticism from Board, staff or public was levelled against Mr Pridgeon. He resigned on account of ill health. At that time the Ashburton Hospital was being built and the Ashburton Board asked the North Canterbury Board if it would permit Mr Pridgeon to visit Ashburton and advise on building and policy matters. Which Mr Pridgeon did. When he left the hospital he intended to act as dispenser to Dr Townend but his health prevented him, and he retired to Rangiora where he died in 1882 at the age of fifty.

So that in 1879 the staff of the hospital was Mr Pridgeon, Dr Campbell and Dr Townend. This, the Board maintained stubbornly, was adequate, and kept pointing out that it could easily get more if more were needed (meaning Dr Chilton). On the other hand the profession was inclined to sneer at the staff. Dr Campbell had previously been dismissed by a royal commission. Dr Townend was referred to in a joint letter from nine previous hospital staff members to the Provincial Secretary as 'Mr Townend whom, though legally qualified, the profession has never recognised in consequence of his advertising himself after the manner of a small tradesman'. (Why small?)

The Board now had its back to the wall, but on the other side was the Colonial Government holding the wall up. Time was on the Board's side if only the hospital services could be maintained. The late staff wrote abusive letters about the Board and sent them to the Colonial Secretary who referred them back to the Board for comment. The comments, florid

and defamatory, were duly returned to the Colonial Secretary who referred them back to the staff for further comment. This game, though utterly pointless in its immediate effects, was subtle in its psychology. The profession's only chance of victory lay in forcing a quick issue and this they could not do. The staff, such as it was, was completely subservient to the Board and the latter referred to the harmonious conditions that existed since certain troublous elements had gone. The patients themselves had poor treatment and the public became uneasy and began, with some justice, to criticise those doctors who would not undertake hospital service. The profession itself, always a little apprehensive about group loyalty, began to hear rumours of impending defections. Gradually public feeling, that intangible quality which is the precursor of public opinion, began to soften towards the Board and harden against the profession. The Board itself was acutely sensitive to this shift. At an appropriate time it abruptly terminated the letter writing campaign by informing the Colonial Secretary that 'The Board considers it unnecessary to waste any more time in replying to specious statements made by certain members of the late hospital staff and confidently relies on the Government sustaining the Board in its voluntary and arduous duties.'

It then followed this up by calling for applications for a new hospital staff of five. An attempt was made to infuse fresh enthusiasm for the resistance movement among the profession but the principles at stake were growing indistinct as they receded in time. The diehards decided there was no need to die yet. There were six applications for the five positions. Dr Prins came back, an obvious selection because of his ability. Dr Campbell and Dr Townend had their loyalty recognised by re-appointment. Dr J. Irving and Dr Wilkin were the new members. The reject was Dr Chilton who had not yet worked out his term of disfavour.

And so the Board won its first fight but the battle honours were few. The Board was harsh and dictatorial and was more concerned with prestige than patients. Though needing the help of the profession it yet abused them. During the height of the struggle the Board's secretary went through the old min-

ute books and changed the title of 'Dr' to 'Mr' in the case of all those who did not possess an M.D.

The profession was equally intolerant. The hospital was a public institution and through it they had certain responsibilities and certain privileges but few rights. There was some basis for their animosity towards the Board but their reprisal of boycott was a foolish one. The ugly word 'strike' was not used, nor could it have been in that private practice was unaffected, but the ingredients of a strike were in the brew. It did not escape public notice that while they were calling on the Board to resign, were boycotting the hospital, bombarding the Colonial Secretary, Mr Pridgeon, late dispenser, with his two ostracised members of the visiting staff were quietly running a hospital of over seventy beds with three admissions a day and three deaths a week.

It is at this stage that Dr Chilton leaves this history. He went to England in 1880. He returned to practice at Waimate and in 1883 settled down in Kaiapoi. Dr Campbell stayed on the staff till 1881 and then resigned as he was going to England. He went with the genuine good wishes of the Board. He embarked at Lyttelton on the *Tararua* with his wife and five children. The ship then went to Timaru for more cargo but was wrecked on Dashing Rocks. There were no survivors. At the next meeting of the Board it was resolved unanimously—'That this Board desires to place on record their deep felt sense of grief at the appalling catastrophe which has overtaken the late member of the hospital staff, Dr Campbell, and his family, and also to express their sense of the great loss sustained not only by this institution but by the entire community in the untimely end of so valuable a life as that of Dr Campbell.'

In contrast Dr Townend went from strength to strength financially and professionally. The gibe that he advertised like a small tradesman may have had a partial origin in the fact that in his early days he charged one shilling and sixpence for medicine and advice, though as he flourished his fees rapidly rose and he effectively buried his financial past by marrying an heiress who was reputed to have assets of about three quarters of a million pounds. A year or so later (about 1898) he died of a hemiplegia. His daughter became the Countess

of Seafield. His very secure place in the medical history of Canterbury however is based, not on his social success, but on the fact that he was the first doctor in the province to introduce aseptic surgery.

One positive result of the conflict however was that the Board established its right to appoint the staff. This authority has never been challenged since. The present Appointments Committee may only recommend; the Board decides.

The Board's victory in 1880 more or less coincided with Mr Pridgeon's resignation. He was replaced as house surgeon by Dr Davis and as dispenser by his assistant Mr L. Hawke who had started his apprenticeship as a pharmacist fourteen months before. In less than a year Dr Davis's health broke down and Dr Mickle acted as locum and was subsequently confirmed in the appointment. Before long the Board heard a rumour that Dr Mickle was doing some surreptitious private practice which was now not permitted. Dr Mickle about the same time heard a rumour of the rumour and two letters, one of resignation and one of dismissal crossed in the mail. There were five applicants for the position. The Board referred them to the staff and the staff with stubborn caution referred them back to the Board saying that they were all good and that it was impossible to differentiate. The Board selected Dr R. B. Robinson who was to occupy the post for several years.

For a few years the visiting staff was as follows:

- 1881 Drs H. H. Prins, D. Campbell, John Wilkins, J. W. Townend and Morton Anderson.
- 1882 Drs H. H. Prins, J. D. Frankish, C. Nedwill, F. J. M. Brittan and Morton Anderson.
- 1883 Drs McBean Stewart, Mickle, J. H. Townend, J. Wilkins, J. D. Frankish and C. Nedwill.
- 1884 Drs M. Stewart, Mickle, Anderson, J. H. Townend, W. Deamer and C. Nedwill.

It will be noted that the staff was changing. Dr Turnbull had retired stating that he would not send any of his patients to hospital and had requested his friends not to do so either. He still remained on the Board. A new member of the Board was Dr Prins who also refused to stand again for the hospital staff.

Dr Morton Anderson was a well known practitioner from Sydenham, brother of Dr Richard Anderson and father of Dr Douglas Anderson. Dr Wilkins was an ophthalmic surgeon. Dr Frankish was a vigorous personality well known in professional and public life. He was a strong advocate of the West Coast railway, acclimatisation and improved drainage. Like Dr Turnbull he had his likes and dislikes and little reticence in declaring them. He once went to Vienna, taking a number of slides of Canterbury scenes to try and attract immigrants. While there he saw Koch's treatment for tuberculosis. His later years were bad ones occasioned by bankruptcy and ill health, physical and mental. Dr Brittan was the first general practitioner in Papanui and for a long time had an exclusive area in the north of the city. Dr Deamer, the elder of two brothers in practice, was a sincere gentlemanly personality much respected by his colleagues. Dr MacBean Stewart, tall, handsome and impressive, had as will be shown later a picturesque career. Dr Nedwill was a likeable, mercurial, peppery Irishman.

Despite its triumph over appointments the Board was cautious and preferred to vary the staff and so avoid accusations of favouritism. Also, though it insisted it was competent to appoint, it was content to leave the allocation of duties to the staff itself. The members were appointed because of their overall ability as doctors and not because of any special ability in medicine or surgery. It was this caution which led to the trouble of 1883.

The five members had been selected by the Board in mid December, and as was the custom the house surgeon summoned them to a meeting to decide on their duties. Unfortunately the day of the meeting was New Year's Day. Dr Guthrie was in the country, Dr Frankish was late and after some argument and a little unpleasantness the meeting was postponed. Four days later the five met. Dr Wilkins was in the chair and was appointed ophthalmic surgeon. Two of the others were then to be selected as physicians and two as surgeons. But three of the four wished to be surgeons. Not only could they not agree on this but they could not agree on the method of selection. Secret ballot, show of hands, drawing of lots, select-

ion by the Board, were all suggested but one member or another vetoed each proposal. On the casting vote of the chairman it was decided to settle the matter then and there by some method. At which Drs Guthrie and Frankish indignantly left. The remaining three members then appointed Drs Stewart and Frankish as surgeons and Drs Guthrie and Townend as physicians. Everyone had got what he wanted except Dr Guthrie, who had the soul of a surgeon and the duties of a physician.

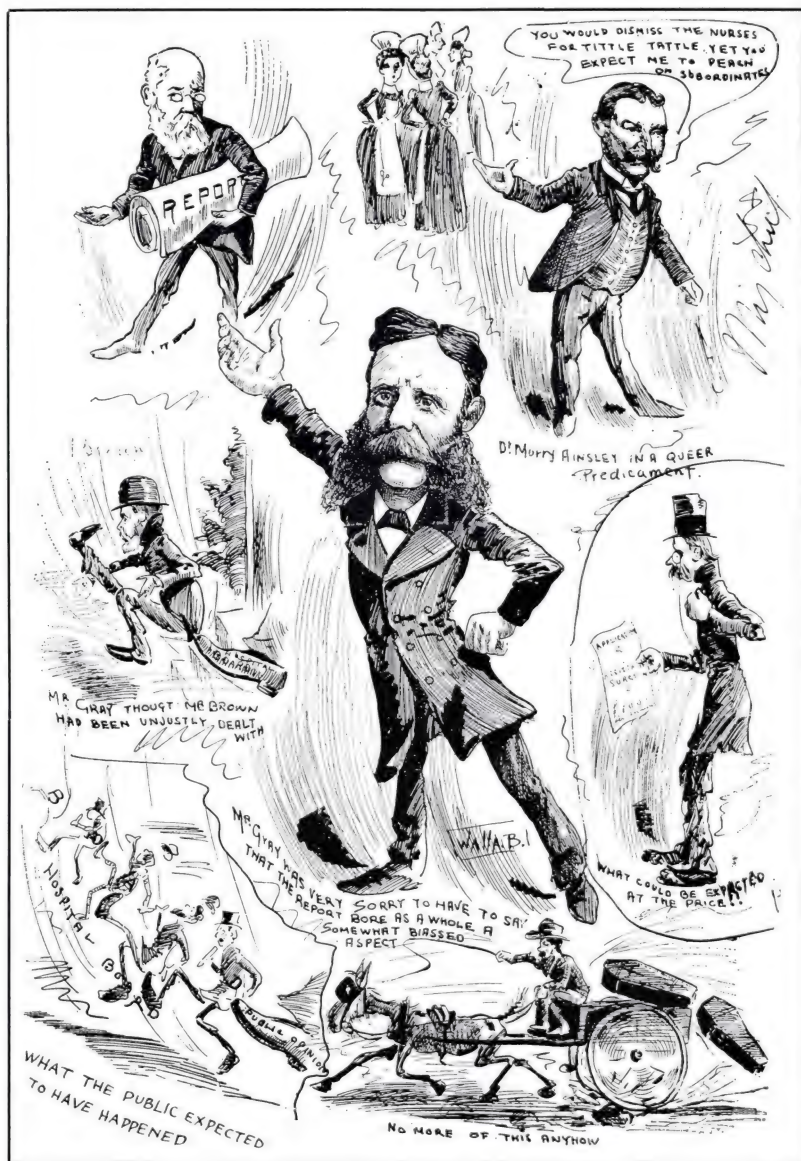
There followed a battery of protest to the Board. It was couched in very different terms from those of three years before. There were frequent references to 'the supreme authority of the Board' and apologetic references to 'taking up the time of the Board through the obduracy of other members of the staff'. Drs Guthrie and Frankish wrote first. Their staff colleagues wrote next deploring 'the bad taste of these gentlemen'. The Board with Olympian-like dignity suggested that they settle their differences among themselves. But Dr Guthrie refused firmly to be a physician. So a successor was called for. Applications were received from Drs Mickle, Bakewell, McClure and Nedwill. The last was appointed.

However Dr Nedwill was also a surgeon and viewed with disfavour the idea of being a compulsory physician. Many of his colleagues agreed with him. A sub-committee of the Board then met the staff and it was decided that the Board should appoint a man, not to the staff, but to a position on the staff. Thereupon, all the present appointments were cancelled and fresh applications called. In the meanwhile, on the Board, Dr Turnbull had persistently advocated the advisability of a physician for the diseases of women and children. Dr Prins had supported him. The Board, recognising that it was a suitable occasion, agreed and so the new post was created and was filled by Dr Frankish. Dr Wilkins became the ophthalmologist. Dr Townend was the only physician to apply, leaving one vacancy. For the two surgical positions there were three applicants—Drs Nedwill, Stewart and Guthrie. The Board which wanted two surgeons and no criticism drew two names out of a hat and once more the unfortunate Dr Guthrie was eliminated. Dr Nedwill who found himself a physician one

day and surgeon the next considered this was unfair to Dr Guthrie and offered to share both duties with him. Dr Guthrie declined this and also a further invitation from the Board to become a physician. So Dr Bakewell was appointed and after eight months resigned and Dr Mickle came back.

Odd rumblings of dissatisfaction among members of the staff continued to be heard up and down the corridor. Dr Wilkins laid charges against the house surgeon which the Board refused to uphold. Other members laid charges against Dr Wilkins of operating before the prescribed hour of 3 p.m. Dr Wilkins replied that ophthalmic surgery demanded a good natural light and he was taking no risks of finishing an operation in the dark. Dr Frankish wrote and gave his reasons for not attending his hospital patients and stated that he did not intend to apply again. The Board, feeling that there would be more loyalty if there were some security of office, decided at the end of 1883 to appoint the staff for a three year period. This was a forward move but the advantages were not immediately apparent. At the end of 1884 Dr Stewart operated on a man with a strangulated hernia who died. Dr Nedwill thereupon resigned because the rule of holding a consultation with all the staff on all major surgical cases had been broken. The Board held a public enquiry which soon settled down into a prodigious recruiting campaign for witnesses by the two doctors which was spoilt by the Board terminating the proceedings at the third session. All public seats were rushed by those who found entertainment in a conflict of evidence and a profusion of incomprehensible technicalities. The only agreement reached was that the patient had died. The Board was inclined to exonerate Dr Stewart; the *Lyttelton Times* in an editorial warmly commended Dr Nedwill. Certainly the paper had reason to be grateful to him. He had given them excellent copy for a number of issues in the dull holiday month of January 1885.

In this sketch of the early doctors the criticism may be made that more emphasis is given to their foibles than to their professional ability. The criticism is just but the records were compiled by those to whom medicine was a mystery but a sensation was news. From other sources there is abundant



The Commission of Enquiry in 1895. *The Spectator* reviews the report.



The hospital between 1876 and 1886.



The creek, the main drain of the hospital for its first twenty-five years.



The old corridor.



The Hospital entrance till 1914 with the porters' lodge on the right and the porters' residence on the left.



Ward 4, probably in the late nineties. Note the central gas brackets.



THE OUTSIDE STAFF IN 1930

Back Row Messrs A. Martin, R. Gavan, R. McCammon, G. Martin, W. Wellington, H. Johnston, V. Marsden, P. Windus, L. Colenso, J. Grimley, S. Hart.

Middle Row Messrs J. Thom, W. Bell, R. A. Rose, G. Smith, F. Knight, A. Hooper, G. H. Abernethy, A. Shipman, J. Pope.

Front Row Messrs G. Challis, A. Norrish, A. Cunningham, E. McCleod, W. Harrop, G. Loughton, W. Drummond, T. Porterfield, V. Morris.

evidence that in general their skill matched the knowledge of their day and that they were active and energetic. But, like any group of individualists, they were poor politicians and they undoubtedly aggravated the tasks of the Board. There were seventeen house surgeons in the first eighteen years. During this time the quietest period in the hospital itself was when it was under the control of the unqualified Mr Pridgeon.

CHAPTER FOUR

CH/29

The Humble Patient

IN THE SIXTIES THE AFFLUENT WERE TREATED AT HOME. THE hospital was reserved for the homeless and the patients therefore were mainly labourers, farm hands, domestics, cooks, apprentices and general servants. They also had to have some qualifying malady and the commonest were accidents and fevers. (The most frequent fatal accident was drowning which was known as the national death.) There was a wide range of fevers. Diphtheria smouldered and surged throughout the years. Lobar pneumonia was frequent, sudden and deadly. One of the commonest maladies was 'laryngitis' and as it was often fatal it may have been of diphtheritic origin. Tuberculosis was introduced by the whalers and there was a heavy incidence among the Maoris before 1850. Fresh air was the only therapy and English medical journals of the time advocated residence in New Zealand. As a result many came and imported the disease especially to Canterbury where the air was supposed to have special properties as long as it remained within the provincial boundaries. The first settler on the plains, John Deans, died of tuberculosis. Godley himself had a tuberculous larynx and died as a result shortly after returning to England. The early records refer frequently to sudden deadly epidemics of influenza restricted to families or small groups. It was unlike what is now recognised as influenza and may have been meningitis. Dr Barker in 1870 says 'This has been a very sickly season—some sort of influenza having swept off whole families. One poor fellow of the name of Dunlop lost his whole family, six in number, in one week.'

But the most frequent fever was the 'low fever', so widely

distributed that it was at times known as the 'colonial fever'. The long history of this protracted epidemic cannot be given here. The great majority of such cases were typhoid which is a bowel and blood infection from contaminated food or drink. On the flat swamps of Christchurch the conditions of spread were ideal. Drinking water in the first instance came from the Avon and later from shallow wells. (Deep artesian water was not discovered till 1864 and not developed till later.) The water from the shallow wells was pure enough at first but was subject to contamination if the soil in the vicinity was infected as it usually was due to the cesspools which were the responsibility of the householder. It was not till 1876 that the Board of Health ordered the closure of all the cesspools in the city area in favour of the nightman but some householders were still resisting ten years later. This closure was an excellent measure even though it was based on the erroneous theory that most infective diseases were caused by bad odours and not by bacteria. When the cesspools went so did many of the dangers. The death rate in 1876 was 30.4 per 1000; in 1885 it was 13.

Pending this reform, resort had to be made to expedencies. The Avon was cleared of watercress (annual contract £65), alum was put in the stinking wells, pools in the road were filled in winter and the water carts came out in summer. For the first twenty five years there was little civil control over the sanitation of Christchurch. The Avon remained the main drain and on his own premises every man did what was right in his own eyes, blind to the relation between the sickness in his house and the refuse, filth, pigs, fowls, flies and cesspool in his backyard.

It is probably true to say that the majority of doctors practising in New Zealand today have never seen a case of typhoid. The present day citizen is protected from a host of evils of which he has never heard. He grumbles at rates and taxes but has no idea of the bargain he has made with communal purchase of health. His predecessor paid also but it was often a costly purchase. When the early settlers moved on to the weedy swamp that was to be Christchurch it was a wretched place. Twenty years later it was less wretched but more dan-

gerous. It was in short a city of abominations, grim and menacing for a hardy pioneer and intolerable for the fastidious.

Ninety years ago the city would be summoned to another day by the dawn on the hills and the roosters in the suburbs. Then would come the heavy tramp of workmen on their way. The heat of the day would begin to beat and a swirl of dust to rise in the street. With the first lift of the wind the faint stale smell of humanity in an unclean city would be apparent to those not inured. There were pot-holes in the streets to which the horse manure would drift, there were flies round the butchers' shops, and dogs uncontrolled. The milkman baled out his tepid milk with a dipper into an open jug or saucepan and left it to the modifications of sun, dust and flies before collection. Opposite sundry houses the odour would alter in character and intensity as evidence that the prudent occupier had invested in a pig or two. Into the earth went the cesspools and from the earth came the water, except in winter when the ground was water-logged and cesspool and well strove for a common level. Then neither wind nor sun could dry the refuse nor could the drains dispose. At night, there was little life in the treacherous and unlit streets. The hotel bars vaguely outlined in kerosene smoke were full and when their clientele departed the honest citizen preferred to be indoors.

But all this was of no importance if it were only an offence against aesthetics. The real tragedy lay in the consequences. When, between midnight and dawn, the town was still, yet, through the night a feeble light would show from scattered windows. Here, often, was man at grips with his enemy, death, and only death was armed. The doctor had come and diagnosed the fever, had prescribed the antimony, the brandy, the arsenic and the beef tea. He had left small consolation but at least some heightening of morale for an unknown fear was worse than a positive diagnosis. More often than not the patient was a child. The distressed parents, having exhausted medical aid, would substitute friends and neighbours who then took turns in 'sitting up' with the patient through the long weary nights of fever and delirium. It was a ritual that was only too often a prelude to death. And in the agony of spirit that came when the breathing ceased and the blind was full

drawn there were thoughts only of the consequences and not of the cause.

In 1872 there were buried in the Barbadoes Street cemetery twenty-six adults and sixty-two children.

In the maturity of its centenary our Christchurch was a lovely city. In its infancy it was a ragged child in filthy garments. It is known as the Garden City. It should be—considering the richness of its compost.

Enough of fever and the other diseases need brief mention only. There were few degenerative diseases—coronary thrombosis, hemiplegias, cancers—for the colony was young. In 1857 there were over 6000 people in Canterbury of whom 90% were under 45. Only 42 were over 60. Almost the only forms of heart failure originated from rheumatic fever. There was better mental health then than now for the social climate of Canterbury was unsuitable for the development of neuroses. The psychoses of course were relatively as common as now. The first mental patients were retained in the Lyttelton Hospital and were intended for the new Christchurch hospital. This produced an outcry and they were then maintained in the Lyttelton Gaol until Sunnyside Hospital was opened in 1864. A report on such cases in 1862 showed that insanity in fourteen males was due to drink in nine, head injury in three and to solitude on outstations in two, while unknown causes were responsible in another male and, naively enough, in all the five females.

Alcohol was probably responsible for much illness for there was an enormous consumption in the early years. Modern Christchurch is relatively much more abstemious. The medical consequences of alcoholism were not fully recognised and its full effect on the nervous system and the liver was unknown. At the same time the diagnosis of 'delirium tremens' was frequently made and in most instances was wrong. Any person with some mental impairment and a tremor was so diagnosed. In the Provincial Council Mr Wylde deplored the West Coast habit of sending so-called neurological cases to Christchurch which on examination turned out to be delirium tremens. Mr Wylde was wrong. Any person with delirium tremens embark-

ing on a coach for Christchurch would have recovered or died before the journey's end.

The inadequate early hospital records supply a little information on the nature of cases. The house surgeon's quarterly report in 1865 cites 5 deaths in a total of 94 cases of fever; surgical operations (under chloroform) were 33 with 3 deaths (tracheotomy, amputation of the hip joint and amputation of the thigh for a diseased joint in a child of 5). Accidents provided 40 cases. There were 15 emergency labours usually in single or destitute women. There is an appreciative reference to the fact that the only instrumental delivery survived. An analysis confined to 75 medical cases between 1866 and 1869 reveals a 44% incidence of fever. There were roughly equal numbers of pneumonia, delirium tremens, heart diseases, phthisis and rheumatism. In 1871 the report notes a decrease in accidents owing to better protection in the flax industry and an increase of fever cases and comment is made on the low mortality in the latter (7%). Overall hospital mortality was 13%.

In 1874 there were 682 cases admitted with 107 deaths. An analysis of the principal diseases in this list reveals the following (deaths in brackets):

Phthisis	28	(7)	Rheumatic Diseases	49	(9)
Fever	167	(23)	Injuries and		
			Fractures	52	(11)
Abscesses and ulcers	38	(8)	Pneumonia	50	(2)
Diphtheria	30	(1)	Confinements	32	(12)

More intimately behind the statistics was the individual patient who, whatever he thought of his treatment, said little. He was not encouraged to say much nor was he often capable of doing so. Though he or someone on his behalf had signed the contract to pay 30/- per week while in hospital he often had not the means and therefore excused himself from the intention. That his treatment should be on a charitable basis was always a grievous matter to the Board but if he had criticised such treatment it would have been intolerable. He was usually young (Average age of hospital patients in 1868 was 22.2; average age in ward 8 in 1958 was 65.3). He frequently

came from outside the city. The patient admitted because of accident or infection was usually either dead or convalescent within a week. The average stay then (as now) was between two and three weeks. The bylaws defined the maximum stay as a month. This obviously could not be observed in many cases but it served as a convenient talking point with those patients who (as in the great depression seventy years later) resisted discharge.

For the convalescent patient life in hospital was a casual sort of existence. Once a day the house surgeon or the visiting physician would make his rounds accompanied by the dispenser and the treatments were ordered. These were usually medicinal with frequent esoteric modifications of the ingredients. When the ward round was finished the ward took on more of the air of a boarding house. The nursing staff, usually recruited from the wardsmails, had little authority. Hygiene standards were low. A complaint of inhuman treatment was once received on behalf of an old man admitted to the Home at Ashburton. This was based on the fact that the staff finding him filthy and covered with vermin had insisted that he have a bath.

Consequently to a large extent the patients tended to please themselves. Doctors are rarely good disciplinarians—unless they are in uniform. Before the hospital was fenced patients often wandered out and went to the town. Sometimes they returned, sometimes not. They frequently brought back alcohol, on or in the person. Similarly, despite formal visiting hours, there was little control over the general public who trafficked in and out of the hospital with uncensored supplies. Therapy which came from bottles was often supplemented by what came from baskets. Periodically there would be an energetic campaign to raise the disciplinary standard but this usually resulted in some sweeping prohibition which was useless unless enforced and which with the advent of the new house surgeon would be forgotten.

For the surgical patients (who were very much in the minority) there was the addition of the daily dressing to the leisured routine. When an accident was admitted a bell was rung at the door and the dresser took charge and either dealt with

the case or called the house surgeon at his discretion. Traumatic surgery and all minor surgery was done in the ward. Major surgery was performed in the theatre at 3 p.m. on Wednesday afternoons and only after full consultation with all the staff. The theatre was a small room in the old block near the entrance to the new corridor and was also used for meetings, lectures and coroners' inquests.

There were no case notes for patients. The whole clerical work of the hospital was minimal. In addition to the treatment register the dispenser had his prescription book, the staff a general register of patients and the steward his register of payments. The house surgeon made a monthly report to the Government or the Board. The first Board did not start to keep minutes till some months after its inception. The paucity of records regarding the early hospital and the complete absence of case notes have led some investigators to assume that there has been some wholesale destruction. This is not so. They did not exist.

CHAPTER FIVE

CH/20

The Range of Therapy

MEDICAL THERAPY IS USUALLY EITHER RATIONAL, BASED ON A knowledge of the pathology, or empirical, based on experience. The former predominates today; the latter was the necessity a century ago.

Yet the old doctors, true disciples of Hippocrates, were keen observers. They had, in conducting their examinations, only their eyes, ears, fingers and a stethoscope. Even the clinical thermometer was not in use until the seventies and then was a crude instrument about ten inches long for placing under the axilla. In the sixties when examining chests they referred to tubular breathing, bronchophony, consolidation, fine crepitations, coarse rales and rusty expectoration. They diagnosed typhoid by general appearance, headache, delirium, distension, slow pulse and the rash, though they did not refer to an enlarged spleen. In heart disease they noted irregularity of the pulses, mitral murmurs, arrhythmias, various bruits with either heart sound or mitral flush. Exploration of the abdomen was rare until the eighties. (At the first B.M.A. conference in Dunedin in 1898 Dr Bachelor of Dunedin read a paper 'Second Series of 100 cases of abdominal section'). Nevertheless the doctors in the sixties were noting enlarged livers, abdominal masses, tympanites, 'tenderness of the right ileum' and free movement of the abdomen on respiration.

We now know that many of their deductions were wrong and a future age will probably pass the same judgment on us. One case in their records is described as typhoid but is almost certainly a peritonitis following appendicitis. Another alleged case of delirium tremens was a Jacksonian epileptic. Dr

Thomas in 1890 described a family of five siblings all of whom had died deeply jaundiced in the first week of life. In the absence of any knowledge of the Rhesus factor he was probably justified in his diagnosis of congenital atresia of the bile ducts. In 1889 a speaker at a medical meeting described a case of congenital occlusion of the auditory meatus and ascribed it to the mother when pregnant being frightened by a dog and clapping her hand over her ear.

The physician shared with his patient an enormous faith in the pharmacopoeia. He issued elaborate prescriptions each of many ingredients and often delicately adjusted the relative quantities daily. There was sincerity in his prescribing because he was unaware that much of it was based on unsound pharmacology. Not all of his *materia medica* has been discarded. A hundred years ago the doctors were using morphine, chloroform, iron, digitalis, santonin, hydrocyanic acid, belladonna, tannic acid and Fowler's solution. They were obsessed with the importance of the persistent function of the colon and the old prescription book of the hospital has an intimidating list of laxatives and purgatives. Their exhibition figures in the therapy of practically all cases—from intestinal obstruction to typhoid. The so called cases of delirium tremens usually got antimony, calomel, rhubarb and jalap in such combinations and strengths that the mixture might well have been prescribed under the heading of Mist Punitive Co.

After the medicines (and enemas) the physicians were left only with external applications—ointments, fomentations, compresses and stupes. Sometimes there is a reference to cupping ('about 2-4 ozs') or leeches ('say 24').

Diphtheria was diagnosed by inspection of the throat. The treatment was by nursing, sustaining food and stimulants, various febrifuges and the shadow of a tracheotomy. Even as late as 1895 there was a discussion in the press regarding treatment and the use of five drops of sulphuric acid or blowing sulphur down the throat had each its advocates. In the same year anti-diphtheritic serum was introduced and was first used on a girl in Sydenham.

The surgeons of course had a greater freedom but were limited by their fear of the consequences. Accidents if produc-

ing open wounds carried a bad prognosis. The dread of the doctor was infection and septicaemia. The dread of the patient was amputation. Both fears were real. (In the Crimea war a decade earlier every man with a compound fracture of the femur died.) The doctor arguing statistically that the best figures for survival of three limbs followed a sacrifice of one was opposed by the patient who argued that his individual case could have no bearing on a statistical group and that he would prefer his four limbs. He often resisted the doctor and made a good recovery and raised doubts in the minds of the amputees as to whether their operations had been necessary. As time went by the public steadily hardened in its insistence on conservative treatment and when antisepsis became possible the doctors agreed. Simple fractures were set and splinted and alignment of the parts was controlled by inspection and palpation. Boils, carbuncles and quinsies were incised and abscesses, cysts and pleurisies were aspirated. Every doctor carried at least one cannula with a neat nest of trocars. Wounds were sutured usually without anaesthetics. When anaesthetics were used chloroform was the one of choice and some later doctors could quote personal series of thousands of anaesthetics without any accidents.

The first doctors in Christchurch to explore new fields in surgery were Dr Prins and Dr Turnbull. The more spectacular operations were reported in the daily paper often with progress notes from time to time. No hospital records of surgical cases were kept and the history of the gradual expansion of surgery in Canterbury is now lost for ever. From various sources the following fragments survive:

- Removal of malignant upper jaw (Dr Turnbull 1864)
- Amputation of hip joint (Dr Turnbull 1865)
- Removal of malignant breast (Dr Prins 1866)
- Lithotomy in a boy (Dr Prins 1879)
- Removal of malignant tongue (Dr Prins 1879)
- Removal of cheek and jawbone (Dr Prins 1879)
- Ovariectomy (Dr McBean Stewart 1883)
- Transplant of cornea from rabbit to man (Dr Wilkins 1883)
- Strangulated hernia (Dr Stewart 1884)

Suturing fractured patella (Dr Leahy—Ashburton 1890)
Hysterectomy (Dr de Renzi 1891)
Cystoscopy (Dr Fenwick 1895)
Gastro-jejunoscopy (Dr Fenwick 1899)
Splenectomy (trauma) (Dr Crooke 1902)
Caesarian plus hysterectomy (Sir Hugh Acland 1904)

The one public health procedure that has survived to the present day is vaccination. There was no compulsion but the public approved and the majority of citizens submitted. This is probably why, though there have been odd cases, there has never been a major epidemic of smallpox in Canterbury. The earliest history of vaccination in the province is hard to elucidate. Presumably in the beginning one patient supplied the lymph for the next. Dr Welsh of Lyttelton advertised in 1854 that he was prepared 'to vaccinate a few children with virus lately taken'. In 1863 Dr Stedman asked for the right to charge £1 a vaccination with the promise to refund all but the standard fee of 2/6 if the patient returned in a week to supply more lymph. The Provincial Council would not approve presumably for reasons of policy rather than pathology. Later the Government appointed a vaccination inspector and manufactured lymph at its farm at Sunnyside and some of this was exported to Australia. There was much jealousy among practitioners over the position of 'public vaccinator' to which the Government usually appointed the House Surgeon at the hospital or the Medical Superintendent at Sunnyside.

The old doctors a century ago lacked nearly every remedy of today but their therapy, though inferior, was by no means negligible. And, like the modern doctor, they had other qualities. To the patient the most important aspect of every illness after the pain is the prognosis and this they could supply. By their bottles of medicine they often practised without knowing it an oblique form of psychotherapy. And they were energetic, painstaking and tireless. It is on record that Dr Donald one night walked from Lyttelton to Belfast and back to see a sick child.

CHAPTER SIX



Essays in Architecture

BY 1869 THE HOSPITAL HAD BY MODIFICATION OF ITS PREMISES and by casual additions begun to acquire the semblance of an institution. It had six wards—two male, two female and two fever, providing a total of 67 beds. It had a vaccination centre and an outpatient department where Dr Parkerson complained that there were as many as 47 patients a day, many of them masquerading as indigents. It had nothing that was not justified by stark necessity. It had for instance no bathroom, the Government insisting that the old portable bath was adequate.

It also had a shortage of beds. It has always had a shortage of beds. This has been the steady persistent undertone of all hospital history. As soon as Dr Parkerson got his additions of 1869 he wanted two more wards and doggedly insisted on them. He quoted the increase of population, the rise of immigration, the industrial accidents (especially flax processing) and the high incidence of fever. The swing of events endorsed his requests. In 1869 the hospital was overflowing and some patients had to be removed to the Armagh street Depot (then the Immigration Barracks). In 1872 during a smallpox scare an emergency hospital had to be established in the office of the Heathcote Road Board at the corner of Ensor's and Ferry Road. The hospital became choked with typhoid cases which is not surprising since they were all nursed in a general ward despite a hardening of medical opinion in favour of isolation.

At last the Government was converted, not only to building but to reversing its past policy of makeshifts and additions. It decided about 1872 that it would build two large permanent fever wards each capable of taking 24 beds and would so site

them that further extensions could be made later if necessary.

So the present wards 4 and 5 were built as a joint contract. The architects were Harman and Stevens, and the contractor was D. Reese (total contract price £3900). They took nearly three years to build. The only detail of the building that can be traced is in the *Lyttelton Times* of March 13 1873. 'The concrete walls of the one ward are already completed and the carpenters are to commence operations at once whilst the concrete work of the second ward will be finished in about eight days'. Dr Parkerson repeatedly urged haste and at one stage suggested temporarily abandoning ward 5 if it would accelerate ward 4. However they were completed together and were handed over to the resident surgeon on May 6 1876.

In their day these were excellent wards. They were connected by a corridor (the present 'old corridor') and this in turn was connected to the old buildings by a covered way. A new imposing block of offices was also built on the other side of the corridor practically opposite ward 4. On the ground floor was a staff room and a waiting room (now the splint department). Above were the house surgeon's premises of two sitting rooms, two bedrooms and a dressing room. (This is the block now known as the A.D.M.S.)

And yet it was not enough. Before the new wards were finished Dr Parkerson was asking for yet another. In 1877 his successor, Dr Guthrie, was making the same demand. The extraordinary thing is that the request was granted. Perhaps Dr Guthrie was specially persuasive as he pointed out that both Dr Stedman and Dr Parkerson had died in hospital of typhoid. Perhaps the control from Wellington was not cautious enough. Perhaps Vogel's borrowing and the subsequent boom had inspired financial indulgence. Whatever the motive ward 6 was erected in 1878.

This is a significant date for from this the real hospital started. All references thereafter are either to the old or the new buildings. The old were now marked for obsolescence and decay. The hospital stream began to flow past them leaving them in a backwash. When wards 4 and 5 were erected there were left three wards in the old building. Ward 1 upstairs, after many changes and constant threat of destruction was

eventually reserved for tuberculous cases. Ward 2 on the ground floor became the main out-patients' department with the dispensary behind it. Ward 3 at the rear of ward 2 was unsatisfactory and in 1879 was demolished. (This was the first ward 3. The present one in Chalmers block is the third). The wing on the eastern extremity of the hospital was given over entirely to the porters, their living quarters being on the top floor. On the west of the wards were the kitchen, the various offices and the living quarters.

Gradually, as will be seen later, when the hospital began to expand beyond ward 6 all these offices had to be transferred nearer the patients and this helped to seal the fate of the old buildings. In 1880 all the patients in wards 1 and 2 were transferred to ward 4 while the old wards were cleaned and distempered. There was a strong inclination to keep them closed and they remained so for nearly a year. Their low ranking among the hospital buildings was shown when a valuation was made for the Board's first fire insurance.

Wards 4, 5 and 6 (£1000 each)	£3000
Furniture in each ward (£100 each)	£300
Corridor	£500
Offices and private apartments	£1000
The old buildings	£1000
Furniture	£400
Laundry and fittings	£500

There must have been much satisfaction with the new wards. The Inspector General of hospitals described ward 6 as 'the model ward of the Colony' and he referred to the corridor as 'a noble and imposing corridor'. The kauri beams that support the roof are noble enough even today though the floor space has suffered from the trespass of neighbouring departments. It was well windowed and shelving below the windows carried flower pots. The view down to the Avon must have been very pleasant even though the present lawns and trees were lacking. The public entrance was off Oxford Terrace and came past the old buildings. The hospital in fact had a far finer entrance than it has now.

The three wards have now altered somewhat from their

original design. Along the passage leading from the corridor each ward had its nurses' room, a side room for special cases, the ward kitchen and a store room. A small staircase led up to the attic where the cleaners and the assistant nurses slept. Inside wards 4 and 5 the most obvious object was the huge central fireplace which gave very little heat and detracted from any sense of spaciousness. The Inspector General, Dr Grabham, in his reports from 1883 to 1885 persisted in disapproval.

'... the drawback of the large fireplaces which take up so much of the floor space.' '... it would be very desirable to remove the present unsightly fireplaces which form obstructions in the wards and smoke badly.' 'The wards would present a handsome appearance were it not for the massive sarcophagus like fireplaces which take up so much room in their midst and are the cause of much trouble from smoke and dirt.' 'The wards have a heavy and gloomy appearance due to the architectural features of the building, the ponderous stoves in their middle and to some want of taste in decorating the walls with suitable and cheerful tints.'

Finally, in 1887, Dr Grabham had his way and the fireplaces were removed. The area in the ceiling through which the chimney passed is still visible today.

One of the last acts of the Provincial Government was to put £600 on its estimates for furnishing wards 4 and 5. Venetian blinds were procured for the lower windows while the upper ones were frosted white. Iron bedsteads with iron lathes were supplied, each with a straw palliasse and a hair mattress. In one ward was one wire mattress reserved for any patient with a fractured spine. Pillows were filled with flock and a few with feathers. There were bedside lockers, a box under the bed for the patient's clothes, some windsor chairs and a few armchairs and rocking chairs. Each ward also had a small washstand and a deal table with forms for meals. Over each bed hung a rope with crossbar by means of which a patient could pull himself up. At the far end of the ward was a projecting annexe containing on one side the bathroom and lavatory and on the other the closets and urinals. The bathrooms were the first in the hospital, ornate creations of marble tiles. Each was equip-

ped with a furnace and boiler and once a week these were set going and a bath queue formed. Emergency baths were possible if hot water were carried from the ward kitchen. Before 1888 there was no exit from the ward at this end where now the main entrance is off the new corridor. At the time the southern end of the wards was practically open country and had to be, to allow twice weekly access by the night man.

Wards 4 and 5 are the grand old veterans of the hospital. Before 1960 they had never closed except for renovations and they had rarely been other than full. They have witnessed an intensity of human effort that outstrips any imagination. Through the two doorways have gone over 8500 patients and four million meals. They have always been the very core of the hospital.

Brass tablets over the doors of wards 5 and 6 carry the respective names of 'Maunsell' and 'Rolleston'. Many are puzzled by the origin of these names.

Charles Thomas Maunsell came from London in the *Castle Eden* in 1851. He was a man of means and purchased about 200 acres in Heathcote and Fendalton. He was the first treasurer of the Canterbury Jockey Club. He returned after a few years and died of heart disease at Limerick in 1859. His will disclosed that he had left a few assets for the purpose of building a hospital ward. He had either considerable faith or foresight because at the time there was no hospital in Christchurch. The assets were not realised until the early seventies and produced about £250 which was doubled by Government subsidy. His executors asked that the ward should be named after him and this was done.

As one ward had to have a name it was seemly that the other should and the choice was simple. The Hon. Wm Rolleston was the Provincial Superintendent at the time. He was held in deep respect and within the limits of his political freedom was a good friend of the hospital. It was appropriate that ward 5 should bear his name.

One at least of the new wards was intended as a fever ward but was never used as such and fever cases were usually nursed in the general wards. Epidemics, mainly typhoid, smouldered and blazed, and the new wards both dealt with them and con-

tributed to them owing to the system of hospital drainage. The nightman dealt with the lavatory pans, the pigman took the kitchen refuse, a carrier removed bulk rubbish but all fluid waste—washing up water, scrubbing water, bath water, urine, pus and blood—went down the sump, under the ward, into the creek in front of the hospital and so into the Avon. The river served many purposes for many people and even to some provided drinking water. Hence fresh cases were always arising and were being sent back to hospital to complete the cycle of infection. This mechanism was not understood then and the only answer that could be supplied by the Board and staff was to build more fever wards.

The Government concurred in this but was a little more progressive in that it made some attempt to stop the fever at its source. It acted on the assumption that typhoid was due to stagnant drainage which was reasonable and that the causative agent was the malodorous effluvia from such drains which was wrong. Its logic then progressed smoothly. If a case of typhoid occurred an offending drain would be found in the vicinity. It was the duty then of the Hospital Board to deal with the typhoid and the duty of the Drainage Board to deal with the drain. As a machinery for implementing this philosophy the Local Board of Health was formed. It had wide powers and its functions were roughly those later assumed by the Health Department. In personnel it was in effect a sub-committee of the Drainage Board.

Under the act constituting the Central Board of Health in Wellington and the Local Boards in the provinces it was the duty of medical practitioners and more particularly house surgeons to notify the Local Board of all infectious fevers. The actual diseases were not listed by name nor were there any footnotes to define the controversial word 'infectious'. The overworked house surgeon frequently neglected to notify such cases and when confronted with specific instances of this neglect admitted that they were fevers but not infectious fevers. The Board of Health bore for a time with this attitude of clinical impregnability but in 1880 decided to challenge it. It asked the Government for a Commission of Enquiry. The Government decided that this was an excellent task for its

newly appointed Inspector of Hospitals, Dr Skae. The Board of Health presented him with the names of five patients who had recently been certified as dying of gastro-enteritis, phrenitis, etc. Dr Skae investigated and firmly changed the diagnosis. They had all died of typhoid. He admitted that every case presented some anomaly but typhoid it had been. Since the patients were dead and buried without post mortem or adequate case notes or laboratory investigation and the main evidence came from untrained discharged night nurses who admitted that they were liable to confuse one case with another, this then was a very clever diagnosis. The Board thought it might even be too clever and sent it to the staff. On their behalf Dr Prins replied in a ponderous letter too lengthy to reproduce. He praised Dr Skae for tackling such a difficult job especially as the latter's main authority was Taylor's text book on jurisprudence and he had not the advantage of the clinicians who had access to such authorities as Murchison, Bristowe, Tanner, Hooper, Guy, Harley and the publications of the Sydenham Society. He was also at a disadvantage in not having the 'large and varied experience calculated to foster that intimate intuitive discernment in diagnosis which constant and unremitting practice, study and observation alone can give'. Dr Prins acknowledged the superiority of Dr Skae's theoretical knowledge on the one branch of medicine in which he was an authority—namely lunacy. What the staff implied in many pages of polite wordiness was that they thought that Dr Skae might even yet be mistaken. What they actually said in stark summary was that he was talking nonsense about something of which he knew nothing. It is possible that the staff may have been right in this opinion; it is equally possible that Dr Skae may have been right in his diagnosis. The staff however did agree with a recommendation of Dr Skae that better records were advisable and that more post mortems should be done. The Board sent its letter on to Wellington during Christmas week and, honour more or less satisfied all round, the matter was dropped. The old system of records persisted. So did the typhoid.

So did the need for fever wards. The Board consulted its staff which was of the opinion that isolation was desirable, new fever wards essential and a remote locality for these impera-

tive. But the Board had no remote locality available and would not have had even a nearer locality had it not received a surprising letter from the local Board of Health.

‘I have the honour by direction of the Christchurch District Local Board of Health to represent to your Board the desirability for health purposes of the grounds in connection with the Christchurch Hospital being extended and to request that you will be so good as to bring the matter under the notice of the Government, pointing out that the next addition to the hospital buildings will render this a necessity. The Board, I might add, are of the opinion that the addition most to be desired is a building for the reception of persons suffering from infectious diseases.

‘The Board are informed that the Acclimatisation Society are agreeable to the extension being made in the direction of the grounds under their control and to the transfer of a portion of the same to the control of your Board.—(Thomas Gordon, secretary).’

The Hospital Board accordingly sent the letter to the Government with the comment that the matter was urgent and that the Board had no money. The Government expressed surprise at the complaisance of the Acclimatisation Society and asked for confirmation. Also, how much land and how much money would be required?

The Board appointed a sub-committee to wait on the Domains Board at its next meeting but both this meeting and the next failed to muster a quorum. The Hospital Board pressed the matter until Mr L. Harper, chairman of the Domains Board, advanced its campaign of casualness a further stage by handing in a memo—

‘The Domains Board are willing to give up to the Hospital Board as much land as they require for extending their buildings. The quantity has been decided on, I believe. It is proposed to straighten out the present fence so as to include more land—how much I cannot say.’

This method of doing business was outside the experience of the Hospital Board. It studied the plan and instructed the

secretary to find out urgently what were the present boundaries of the hospital and who owned the hospital anyway? The secretary's investigations had gone no further than to establish that it was the Domains Board and not the Acclimatisation Society that had the final say when another letter was received from Mr Harper.

'Although I have not succeeded in getting together the members of the Domains Board at a formal meeting I have the consent of individual members to the proposal that the Hospital Board should extend the hospital grounds in the manner indicated by them and therefore on behalf of the Board am prepared to give the necessary permission to do so whenever they deem it advisable.'

After this there was much tramping over the site by the Hospital Board and eventually it submitted a sketch of the proposed acquisition to the Domains Board. The latter, as if bored by the whole affair, agreed without comment. The Hospital Board, almost furtively, surveyed it, found it to be $4\frac{1}{2}$ acres and put a fence round it.

A curious interlude, this, because no one raised the old battle cry of 'Hands off Hagley Park'. Presumably the public did not know. Had the Domains Board effected a quorum and a formal meeting been duly reported in the press the infamy of the Hospital Board would have been revealed and so would have the loyalty of the public.

Building on the new site was limited to the fence as the Hospital Board had no money nor had the Government. Penury was a powerful argument and had to be accepted by the Board of Health.

But it was not prepared to accept the Hospital Board's indifference to the prevention of fever cases and it raised once more the question of hospital drainage. The Hospital Board shrugged this off for it had bigger problems inside the hospital itself. The main one was the kitchen. It was too small and the drift of the new wards had left it isolated. The range was burnt out and was consuming a ton of coal a week. (The bill for fuel in 1879 was £379). A new range was imperative. Given this there would have to be a new chimney. This would be half way

to a new kitchen. A new kitchen would mean new store rooms in the vicinity. If all this were done it would be folly to overlook the necessity for a servants' dining room. Eventually the gap between the Board's aspirations and its finances became so vast that plans and estimates were prepared and hopefully sent to Wellington. The Government replied that it would advance £500 if the total cost were not above £1000. The Board replied that it would cost much more. To paint the three new wards alone might cost £1000. (Actually it was done by Mr T. Beale for £243). The correspondence continued, the Board wanting a new kitchen, the Government imploring it to be content with a new range. The Government wearied first. It agreed to advance £1000.

With this a new kitchen might have been possible had it not been for the Board of Health which was still brooding on the matter of drains and was determined that the Hospital Board should do likewise. In July 1883 the secretary of the latter Board received a letter.

SIR,

I am directed to furnish you with an estimate for connecting the hospital with the existing sewer in Oxford Terrace at Cashel Street and also the approximate cost of the work in the hospital grounds.

Laying 9" pipes along Oxford Terrace from Antigua Street to Cashel Street with manholes and flushing tank complete. (Length 28½ chains)	£360
Cost of pipes for same	£101
Approximate cost of internal arrangements including main and branch house drains, W.C.s, baths, lavatory connections, water service and connection with morgue—complete.	£450

Total £911.

Yours etc.

EDWIN CUTHBERT, Engineer.'

This letter with its implied threat to the kitchen was promptly referred to the Government which wrote back and suggested that the two Boards should hold a conference. But the local atmosphere was not suitable for a conference. The

Drainage Board did consent to supply the pipes but killed the gesture by intimating that the Hospital Board would also have to connect the Armagh Street Depot with the sewer.

The Hospital Board, kitchen conscious, began to be alarmed. It conferred with the staff which was inclined to favour the Drainage Board. It conferred with the Colonial Secretary, the Hon. T. Dick, who was sympathetic, non-committal and penniless. It then wrote to the Drainage Board refusing responsibility and sent a telegram to the Government asking that the kitchen be treated as a matter of urgency. This evoked a long reply. After reviewing all the correspondence the Government regretted that it had not the money for both projects and the Board should decide which was the more important, kitchen or drainage.

The Board wired back 'Kitchen'.

The Government replied 'Send kitchen plans then'.

At this stage the Drainage Board, still rigid in its thesis that a drain after all was a drain while a kitchen could be an extravagance wrote again to the chairman of the Hospital Board.

'SIR,

I am instructed by the above Board to inform you that, as notwithstanding the notice served upon you on August 2nd last, you still continue to discharge the sewage from the hospital by means of the river Avon, the Board has decided to take steps whereby your premises will be disconnected with the stream and that unless the offence be immediately discontinued the Board will proceed in this manner.

THOS. GORDON,
Chairman.'

This letter was immediately sent off to Wellington and in due course a reply came which had little in it except to pose another question. 'Must the hospital be at once connected with the main sewer or is Mr Gordon's letter merely looked on as a threat which will not be carried out?'

This was something the Board could not answer and said so

by telegram, adding—'But both kitchen and drainage are urgent. In the meantime the kitchen range has collapsed.'

The Drainage Board now began to press home its advantage. The Hospital Board received another letter.

'We are instructed by the Drainage Board to prosecute the Hospital Board for causing offensive drainage matter to flow into the Avon. As the Drainage Board has exhausted every effort to get this nuisance abated without success they have no alternative but to prosecute in the matter; will you therefore be good enough to refer us to a solicitor who will accept service of process to prevent the unpleasantness of having to effect same personally. Your immediate reply will oblige.

Yours truly,

GARRICK AND CO.'

This produced a flurry of telegrams between the Colonial Secretary and the Hospital Board.

'Colonial Secretary authorises immediate purchase of a kitchen range but cannot sanction further expenditure till result of action taken by Drainage Board is known.'

'See letter from Garrick and Co. New kitchen urgent. £1000 must not be allowed to lapse.'

'When was hospital built?'

'1862.'

In May 1884 a deputation from the Board met the Hon. T. Dick who had an unhappy time. The Board stated that a sewer in Oxford Terrace would benefit all the houses on the route and was not a hospital matter. The Government should pay. The Government was paying for the sewers at Sunnyside and at the Addington workshops. Why exempt the hospital? Because of its locality said Mr Dick. The Government could not go pulling up the streets of Christchurch. The matter was between the citizens of Christchurch who paid the rates and the Drainage Board which expended them. The mayor of Christchurch (who was a member of both Boards) said that most of the patients in the hospital came from a distance and had nothing to do with the citizens of Christchurch. He also argued that six per cent interest on the £1000 would be £60

which was exactly the sum that would be saved by dismissing the nightman. But Mr Dick would not have it. The Government could not afford kitchen and drains. Which did the Board want? It could not have both. There was £1000 for either. He was sick of the £1000 and would be glad to get rid of it. If the decision was for the drains he would favourably consider some Government expenditure on labour. He was asked if he would also favourably consider the anomalous position of Hospital Boards with no authority, constitution, funds nor right of election. All this, promised Mr Dick would be remedied by pending legislation. It was a matter of time and patience.

But, he was asked, what if the Drainage Board proceeded against the Hospital Board for perpetuating a nuisance? This, said Mr Dick, was also a matter of time. If a nuisance had persisted for over twenty years it was no longer a nuisance legally. The hospital drainage had persisted for twenty-two years. The Drainage Board could take no action.

The conference talked itself out and dissolved with mutual expressions of thanks and goodwill. The Board met a few days later. Now that it could defy the Drainage Board it was loth to do so, for it realised that the drainage was appallingly bad. It looked again at the kitchen plans, folded them up and gave them back sadly to the secretary for safe keeping. It then telegraphed to the Government that the Board was unanimously in favour of the drainage scheme and that it was urgent.

So the sewer was laid along Oxford Terrace in 1884. The Government paid for the labour, the Hospital Board for the pipes and the Drainage Board for the incidentals. It was not till a year later that the reticulation in the hospital was effected and again the Government paid. Dr Grabham, successor to Dr Skae, was very sceptical of the delay but in January 1886 was able to report—

‘I was glad to find that the hospital is now connected with the main drains of the city. Water closets have everywhere taken the place of the dry earth pans and the creek running round the building has been cleared of its accumulated mud and weeds. This must be regarded as a vast sanitary im-

provement, aided as it is by a new artesian water supply with additional tanks for storage. Water is now abundant and runs to waste.'

So much for the story of hospital drainage and it is a rare bit for the cynic if he overlooks the fact that thirty years before Christchurch had been a swamp and local government, despite a depression, was courageously shaping the city to be. The argument between the Hospital and the Drainage Board was not over principles but over priorities. It is obvious now that the final decision was right and both parties emerged with some degree of credit. The history of the Drainage Board has no place in a history of the Hospital Board but it can at least be said here that despite its difficulties, its obstructions, its impecuniousness it performed great and essential tasks and, far more than anyone knew at the time, was a most important guardian of the public health.

When the practice of appointing a master at the hospital ceased his duties had to be taken over by the house surgeon who had equal authority in the kitchen and in the operating theatre. As the house surgeons changed so rapidly it is obvious that they were very unlikely to have mastered the details of the domestic arrangements, and the Board's continual suspicion that some of the stores were being misappropriated may have had some justification. It could hardly be otherwise owing to the fact that there was no storeroom for bulk supplies, which had to be scattered all over the hospital.

The stores were supplied by six-monthly local tender, the lowest being invariably accepted. As a result the goods were sometimes of doubtful quality. (Meat in 1860 was twopence a lb; milk in 1880 was sevenpence halfpenny a gallon). Up till 1872 drugs and medical supplies were imported direct from England but thereafter some were supplied by local tender, the first such order going to Messrs Kempthorne Prosser and Co. An important part of the medical supplies was alcohol which was freely used both for patients and staff. The daily issue of beer or spirits was almost a routine and even children could get their brandy. The more serious cases received port wine and if the patient were dying the prescription was often

'port wine ad lib'. There was a curious faith in the virtues of alcohol. Dr Barker, writing of his ailing horse, complained that it had already cost him in port wine and brandy more than the animal was worth. Tenders for alcohol had to be accompanied by samples and it was the duty of the house surgeon to taste these and report on their merits. The cost of alcohol, relative to other commodities, is shown by the hospital expenditure in 1867.

Diets, etc.	£1000	Crockery, etc.	£100
Wines and spirits	£250	Surgical materials	£100
Ale for nurses	£30	Undertaker	£120
Fuel	£150	Consultation fees	£105
Drugs	£150		

Lighting was by kerosene lamps and after lights out the nurses carried candles. The novelty of gas was introduced in 1871, the Government stipulating that it should not cost more than £150 to install. At first the burners were unsatisfactory in the wards. If the gas was turned up they burned too fiercely. If turned low they went out. They were equally unsatisfactory outside the wards as the domestic staff kept them burning well into the night. The house surgeon in the mid seventies rectified this by securing an independent supply for the servants. This was controlled from the main and thereafter lights out had a literal meaning.

Water was first supplied in 1862 from a shallow well sunk in the shingle bed in front of the hospital. Its purity was naturally suspect and the Government asked Drs Stedman and Parkerson for an official report. This they supplied in the confident terms of clinicians.

'We, the medical officers of the Christchurch hospital, have been requested to inspect and report on the water supply to that institution. We believe that the water, though not absolutely of first quality, is as good as could be procured in the locality.'

The hospital quickly took advantage of the discovery of artesian water in the early sixties. Three artesian wells were sunk, fitted with rams and thereafter the main problem of

supply was the provision of suitable tank stands. For nearly twenty years there were no fire fighting appliances at the hospital and no fire insurance. There was however an electric bell communication with the police station. The purpose seems singularly obscure. The first hospital fire did not occur until 1908.

About 1879 the Board tried to free the house surgeon of some of his domestic responsibility by appointing a house steward in the person of Mr R. T. Bell. He became responsible for stores, maintenance, collection of fees and anything else that would fall to the lot of a general handyman. It was soon apparent that his ability was more in matters mechanical than in administration. He kept no store ledger and he seemed powerless against the petty thieving of crockery, cutlery and alcohol. He accepted valuables from patients for safe keeping but had no property book nor were any receipts given. He collected accounts as well as he could but there was also a debt collector whose means of livelihood was ten per cent of his collections. The post was always easy to fill (there were once 76 applicants) but was hard to retain as the collector was soon as impecunious as any on his list.

Mr Bell had more success in the hospital grounds. The initial work among the mud and the weeds had been done by prisoners. Those sentenced to hard labour worked in gangs on various public projects and at odd times the hospital grounds benefited in this way. But the hospital had a low priority. On one occasion the gang was subjected to a judicial form of compulsory chivalry and was removed to help build the women's gaol at Addington. It in turn was followed by the charitable aid men who otherwise would have been unemployed. They were paid 5/- per day by the Board which failed frequently to persuade the Domains Board to bear some of this expense. By these means the grounds were cleared, lawns were laid and quick growing trees planted. Mr Bell persistently cut these out for fuel and substituted many of the present birch, oaks, limes and chestnuts. At one stage the Board became concerned over patients smoking in wards and corridors and considered converting the old convalescent ward 3 into a smoking room. However it was too useless even for this and

was pulled down. The suggestion was then made that the timber should be used for building a new smoking room until it was discovered that Mr Bell had already used the timber for fences, bridges over the creek in front of the hospital and a wooden shed for the horses of the staff.

The hospital was fenced about 1875 and this included the imposing entrance from Oxford Terrace past the porters' lodge. At the other end of the hospital where wards 12 and 13 now are, an orchard was developed by Mr Bell and a hospital garden was established on the site of the present tennis courts. The first gardener (£45 a year and keep) was appointed in 1881. A permanent carpenter was also secured about the same time.

From the early seventies the hospital began to profit from private and public interest. A library was present from the beginning, starting with a press appeal by the Provincial Secretary, Mr T. W. Maude (father of Nurse Maude). The response, supplemented by a collecting box on the railway station soon resulted in a library of over 200 volumes. This was maintained by the out patient fees for vaccination, but eventually the library could not usefully absorb these fees and Dr Prins suggested that a surplus of £14 should form the nucleus of a fund to help 'indigent patients going home', the same to be administered by the Rev. H. Torlesse and himself. The Provincial Secretary (who had just refused Dr Prins's application for £50 for medical text books) agreed and so began the famous first Destitute Patients' Fund. It was jealously controlled by the staff for some years (which grudgingly handed it temporarily to the Board in small sums in order to get the Government subsidy) then by the house steward and was finally transferred to the Hospital Lady Visitors' Association in 1894.

Not all benevolence was welcome. An anonymous lady once left a carriage and horse at the hospital door for the use of convalescent patients. Dr Parkerson was not pleased. The subsequent lengthy correspondence may be condensed.

Dr Parkerson: 'I should like to be informed of the wishes of the Government in providing for the maintenance of the horse.'

Provincial Secretary: 'Can't you feed it on grass?'

Dr Parkerson: 'Sir, there is no grass at the hospital.'

Provincial Secretary: 'Then get some hay from Sunnyside.'

Dr Parkerson to Mr Seager of Sunnyside: 'Can you supply half a ton of hay?'

Mr Seager: 'Yes—provided there is a sufficient stock on hand.'

Then, as now, the disposal of the convalescent patient was difficult and a horse and carriage was no solution. The bleak future of the horse faced with pioneer work on the hay diet was obviated by Dr Parkerson getting permission to sell the whole outfit and apply the proceeds to the patients' library.

CHAPTER SEVEN



Politics and Procedures

THE DIFFICULTIES OF THE FIRST HOSPITAL BOARD WERE largely due to the fact that its function had to be determined by experiment. The Government regarded it as a buffer between the dignity of Wellington and the trivialities of a province. The doctors regarded it as a householder might regard the stranger found pitching a tent on the lawn. The public regarded it as an organisation capable of paying out a guinea for every pound received from rates. The Board itself, aware of all these attitudes (for it was a very vocal age), put on the armour of responsibility confident that this would turn the barbs of its critics not only on the hospital scene but also in the other areas outside. These included the orphanage and casualty ward at Lyttelton, the Akaroa hospital built in 1876, the Armagh street Depot and the old men's home at Ashburton. But its greatest burden was charitable aid. From its meagre funds it supported all these but failed to convince any one that it was not being sacrificed for the others. And when faced with an emergency it invariably appealed to the Colonial Government.

So did all the provinces, each trying to bolster up its own peculiar fabric of social service. The Government found this intolerable especially as the provinces continually flayed it with precedents and comparisons. It gave grudgingly while it sought for some formula that would establish a national policy for hospitals and charitable aid. From 1877 to 1885 it presented various bills seeking to establish a common pattern of rating and control but all failed to pass.

At last the chaos began to clear. This was done by the pass-

ing of The Hospital and Charitable Aid Institutions Act of 1885 and its Amendment of 1886. The essential terms were very simple. Hospital districts were defined. Local Boards were to control. Finance was to be raised from rates and the Government was to subsidise these by fifty per cent. Charitable Aid was to be separated from hospital work though the method of control and finance were similar.

This is the most important act in the history of New Zealand hospitals. Though the method of finance has now changed and social security has replaced charitable aid the other essentials in the act still persist.

The North Canterbury Hospital district included 'all that area in the colony being the counties of Kaikoura, Amuri, Cheviot, Ashley, Akaroa and Selwyn and including all the boroughs therein'. (The Charitable Aid Board operated over the same field but included the Ashburton district, being 'The Ashburton and North Canterbury United Charitable Aid Board'.)

The Boards had considerable power. Each was a body corporate with the usual privileges of such. It raised money by drawing up its estimates for the year and sending its demand for half of this total to each county or borough proportionate to its rateable value. The temptation of a Board to make reckless levies was offset by the fact that the Board was composed of the elected representatives of these same counties and boroughs. (One member for every 8000 inhabitants with a maximum of two). In one capacity they wanted the levy low and in another they wanted it high. Board members were therefore vulnerable from both sides and had no easy task. But the principle of no taxation without representation had been established.

Such was the Act. It was practical and as a result had a positive appeal in the struggling days of colonisation. And yet the care that had gone into the mechanics of its administration had overlooked all the conflicts of human emotions that operate in the case of the sick and the needy. It tended to simplify a problem that by its very nature can never be simple. In the minds of the legislators, each Board, supreme in its legal status, confident of its income, had merely to give audience to the

supplicant and dispense therapy or aid according to the merits of each case. It was not foreseen that the legal status was sometimes in conflict with the angry moods of hungry people, that the incomes of the Boards were in inverse ratio to their needs according to the prosperity of the day, that the local bodies had at times to be sued for their contributions, that the annual budget could never be satisfactorily forecast, that a critical public was always ready to seize on the injustice and that 'the merits of each case' was, by all human standards, then as now, impossible to establish.

Before leaving that period of history which naturally terminates with the Act of 1885 it is necessary to refer to the hospital as an educational institution. The Canterbury Association, confident of the profits that would result from buying land from the New Zealand Company at 10/- an acre and selling it at £3 had decided to spend one third of this sum on religious and educational endowments. Educational expansion was to be by means of Christchurch College (later known as Christ's College). There were to be two departments—a lower Grammar school for boys seven to seventeen, and an upper college, equivalent to a university for those over that age. The college was to provide instruction in many subjects including medicine and the hospital was to be available for clinical work. It was a nice concept. All that was then necessary was money, staff, organisation, buildings and students.

For the first twenty five years nothing was done except that in 1858 the Association instructed its agent to take the appropriate steps to start the project. But there were no steps to take. In the first twelve years there was no hospital; in the next twelve there was no money. But in 1875 the medical school started in Dunedin. This was a threat dangerously near and stimulated defensive action in Christchurch. The Provincial Council put £300 on its estimates for a medical school and called a conference between the hospital staff and the Board of Governors of Canterbury College, which, two years before had received the affiliation of Christ's College. After some discussion the conference adjourned pending a considered report from the hospital staff.

In February 1876 Dr Prins, chairman of the staff, presented

this report. It was strongly in favour of the formation of a medical school to be incorporated in Canterbury College. It would be costly and would require heavy endowments. The doctors would form a Faculty and provide the instruction if the college would find the money. He submitted a suggested staffing for the Faculty.

LECTURERS

Medicine—Drs Deamer
and Frankish
Surgery—Dr Nedwill
Operative Surgery—Dr Prins
Diseases of Women—
Dr Turnbull
Anatomy—Dr Campbell
Physiology—Dr Powell

DEMONSTRATORS

Anatomy—Dr Symes
Pathology—Dr Doyle
Materia Medica—Dr Hay
Med. Jurisprudence—
Dr Coward
Ophthalmic Surgery—
Dr Powell
Botany—Dr Guthrie
Chemistry—

Mr A. W. Bickerton

All this seemed very smooth and on September 15, 1876, the Provincial Gazette proclaimed the establishment of a Medical School in Canterbury University College.

But by the next year matters were far from smooth. It appeared that the proclamation was null and void in that it had not been preceded by an ordinance. It was now too late for this for in the meanwhile the Provincial Government had ceased to exist. The College Board did what it could. It approved the recognition of the School (if ever the Colonial Government should do likewise) and appointed a council of five of its members with five members of the Faculty. Dr Turnbull became the first Dean. And a reserve of 5000 acres was set aside as an endowment for the School. There remained then only for the Colonial Government to do what the Provincial Government had failed to do. The Premier, Sir George Grey, was sympathetic and promised the appropriate legislation and further reserves.

Then came a tumult of disasters. Sir George Grey was replaced by Sir John Hall. The legislation was shelved. The Government had no funds. The reserve could get no tenants. The first Hospital Board was appointed and the doctors boycotted

the hospital. Instead of recognising the Faculty in the hospital the Government dismissed its members from the staff.

There remained the reserves and they still remain to the present day. They figure in the annual balance sheet of Canterbury College as 'Medical School Reserves Account'. The income is applied to the cost of instructing medical students in their first or intermediate year. Only a fragment of legislation, now eighty five years overdue, prevents Canterbury College from having a Medical School. Many a medical course has been marred by a long stay at the intermediate stage. Such is the lamentable effect of precedent.

The Board met for the first time. By order of the Government the convening chairman was Mr Vincent but he was replaced as permanent chairman by Mr Beetham, S.M. A Finance Committee and a House Committee were set up. Messrs Holmes and Loughney were appointed solicitors. Estimates were prepared and levy notices sent to the contributory bodies.

The Board considered its staff. A new officer was required to be secretary, treasurer and house steward. From 33 applicants Mr W. Miller was successful. He had been secretary of the late Avonside Benevolent Association and as a storekeeper on the West Coast he had a practical knowledge of goods and supplies. His salary was £200 without residence. The internal staff of the hospital was as follows. (Salaries include keep.)

Resident Surgeon	£250	1 Cook	£80
Matron	£100	1 Assistant Cook	£40
Dispenser	£100	2 Laundresses	£40
3 Day Nurses	£45	1 Scullery Boy	£30
3 Assistant Nurses	£30	2 Wardsmen	£80
2 Night Nurses	£30	1 Gatekeeper	£39
2 Housemaids	£25	1 Gardener	£52

To the Board these were legacies of an era that was now in process of reform. The loyalty of this staff to the new control had been neither promised nor proven and the Board decided to put it to the test at once. Under its instructions the secretary addressed to each member of the staff, from the resident surgeon to the scullery boy, a letter informing him or her that he

was dismissed as from the end of the month but inviting him to re-apply (which most did). Having thus demonstrated that its authority was in good working order the Board proceeded to consolidate the position by drawing up a fresh set of bylaws.

There is little doubt from some of the statements of Board members that they failed to understand their function. With a competent staff and an income assured by law and adequate by their own resolution they imagined that they had merely to supervise and hold delicately the balance between efficiency and economy.

It was a nice dream but it had the usual defects of the academic approach. The funds were inadequate. The public and the Board disagreed over efficiency and economy. The hospital was too small. The services were faulty. The staff was restive. The Board was prepared to foster progress but too many new ideas, all costly, were bewildering. The Board needed courageous and informed planners. Instead it had conservative business men and freehold farmers.

At the second meeting the House Surgeon requested a new operating theatre, a children's ward, more female beds and improved heating in the three main wards. This revealed the major weakness of the new Act. No money for capital expenditure could come from levies. The Act did not say where it was to be found. It implied that public appeals, legacies and donations were regarded with such favour that the Government would subsidise them. There was a tacit understanding that if a Board were desperate (and could prove it) the Government might make a capital grant. It was fortunate for the Board that it was already receiving a steady annual income from previous bequests. These, with a manipulation of the annual levies in such a way that there was often a small surplus enabled some new work to be undertaken.

The first of these works was a modification and a refurnishing of wards 1 and 2. At the same time was added the balcony which improved the outside appearance and effectively darkened the interior. When completed ward 1 upstairs had two rooms, one for chronic male cases and one for ophthalmic cases. Ward 2 downstairs was, for a time at least, used primarily for chronic female cases, though some children were there

and it was often referred to as the children's ward. Policy decided this title. The contract price for the renovations was £1082 and £250 of this came from the Maxwell bequest of £1000. The executors had expressed a preference for a children's ward. The Board could not supply the ward but they could at least supply the name. It is doubtful if the money was well spent for the wards were never satisfactory. In the opinion of the honorary staff they were hopelessly impregnated with germs. (The enterprising Dr Symes wanted to experiment with paraffin oil on the floor to seal in the germs but the Board preferred the germs.) Dr Fenwick in 1895 described the eye ward as the most dismal he had ever seen.

These changes in the old block did little to improve the bed state in the new where three wards housed most of the patients then numbering 60-70. As soon as the Board took office the staff pointed out that a new ward was imperative and that it had of course to be a fever ward. Was there no way, asked the Board, whereby diphtherias and typhoids could be nursed in the general wards? There was no way at all said the staff.

So a new ward was planned in 1886 and built in 1887 by Mr A. Clephane (£1543). It was demolished in 1914. Three separate wards in the hospital have been known as ward 3 and this was the second of them. The Government made a special grant of £1000 and the remaining £750 of the Maxwell bequest supplied the rest. Being an infectious ward it had to be remote from the main buildings and the site selected was north west of ward 6 roughly where the present theatre block now stands. On its completion the total bed state was 116.

It was not a very significant ward. There were six beds on each of its two floors. The Board had no intention of keeping it open and staffed if there were no cases and despite the protests of the staff it remained closed for lengthy periods.

Except for the Hyman Marks wards in 1897 there were no further additions to the bed state until 1910. But there was a great expansion of facilities. Piece by piece the old block was stripped of its functions as new services were installed round wards 4, 5 and 6. As the new theatre, kitchen and boiler house were created so did the old portion accelerate in its deterioration until it was finally removed by the demolition gang that

cleared the way for the Chalmers Block in 1917. There is much talk at present of rebuilding the hospital. It has already once been done.

More might have been done if there had been less agony over the spending of money. It was soon revealed that the new legislation had fused the contributory bodies into a positive opposition. The Amuri County for instance refused to pay its first levy and the Board had to appeal to the Court. Sydenham which always drew heavily on the Board's resources protested the most at the money spent. Payment was deferred to the last possible moment and frequently followed a threat of summons. As the subsidy was not available till the levy had been paid the Board operated mainly on an overdraft and through the years has paid many thousands of pounds in interest. The Board itself was composed of men elected because they could be trusted to prosecute a policy of rigid economy. But economy in the borough often became parsimony on the Board. The staff could convince the Board as a whole that a new theatre was a necessity and the Borough could convince its representative that a theatre was an extravagance.

Thus arose an attitude of mind that stifled progress. Every proposal was considered primarily on the basis of cost. When the staff talked of isolation, asepsis and surgical instruments the Board could not contest the technical details. But all other expenditure was reduced to a minimum. Until the end of the century the Board initiated nothing of itself. The work that was effected was always the result of pressure from some other quarter. The gatekeeper had to apply in writing for his annual uniform; all holidays were granted after individual request; linen, furniture, instruments and crockery could never be approved till the written application had been received. Nothing was granted as of right. During the years the cost of living rose but the wages remained the same except in the special instance. At almost every meeting of the House Committee there was an application for an increase of salary and almost invariably the reply was 'The Board cannot see its way to accede to the request'. In 1896 the mattress maker was successful in getting an extra sixpence a day. So were two workmen the next month, but after that for a long time the bounty stopped. In the

1896 bylaws the salaries of the nurses were stated in fixed terms and thereafter the Board could always regret that it was bound by the bylaws. The House Committee on one occasion debated lengthily whether it would refund to the police the railway fare for a sick patient. The sum was 4/9d. An enquiry was held into who stole the shilling's worth of tobacco from the dispensary; another into who tore up the old tablecloth. The nurses were refused washable print uniforms because of the increased laundry costs. Contractors for supplies frequently had their goods rejected or their payments withheld. Two members of the House Committee (later one) attended out-patients twice a week to determine who should get free medicine. It was a costly economy that produced cheap goods and threatened to produce cheap service. An example that illustrates this is the story of the water tower.

In 1896 the new Marks wards were going to necessitate an improved water storage system for the hospital. The House Committee therefore called tenders for a water tower, 40 feet high and to support tanks with a capacity of 25,000 gallons. That of Scott Bros. at £599 was accepted subject to Professor Scott approving the stability. He recommended alterations that would cost another £250. He was thanked, paid, and withdrew. The four original tenderers were then asked to tender again. Only one did. The Committee rejected this and called for competitive designs. Four were received and the winner was Mr P. Hunt, who had had the wisdom to select for his code name 'Palman qui meruit ferat'. He then, on request, prepared plans and specifications preparatory to calling fresh tenders. He was also asked for an estimate of the cost and was informed that if the tenders exceeded the estimate he would not get paid. He protected himself by estimating £1000. The Committee thereupon repudiated everything to do with Mr Hunt including his account for £70 though it was eventually forced to pay £52. It then took up the original tender of Scott Bros. with the stipulation that Mr Dobson, Civil Engineer, should supervise the work. After a time Mr Dobson complained that Scott Bros., unable to get the specified Worthington pump from England had imported an alternative from Australia and this Mr Dobson refused to accept. Scott Bros. then sent the pump back,

threw up the contract and submitted accounts for £37 for preparing the design and £14 for importing the pump. This was paid as well as Mr Dobson's account for £15/15/-. Mr Clarkson was then asked to draw up plans for a structure costing £250. Tenders were called but were all rejected in favour of a proposal to install the tanks in the roof of the Marks wards which was then building ('making due allowance for leakage'). But the Board did not agree and the architects were sceptical. Having paid Mr Clarkson's fee of £13 the Committee was back where it had started except that it had paid £150 for advice that it refused to accept. It then decided on a much simpler structure and an architect Mr Whitelaw was asked to design something costing no more than £150. The stand was eventually built by Mr G. R. Rankin for £139. Fifteen years later it was demolished.

As was to be expected it was not a happy hospital. When the Board assumed office the house surgeon was Dr R. B. Robinson who, under the old Board, had shouldered most of the responsibility. He was an able doctor but not an easy personality and a wise Board, wanting his loyalty, would have approached him with diplomacy and tact. Instead it dismissed him and re-appointed him. Dr Robinson felt that the future was dark. After a few troubled weeks under the new régime a friend one day gave him a bottle of whisky. It was the perfect answer to his present mood. Unfortunately he did not know that the House Committee was to hold a special meeting that day and was to ask him to appear. With some difficulty he did appear having acquired a new conception of the relative unimportance of a House Committee. Before he had convinced them of this he had ceased to be the house surgeon and the next day Dr Doyle took over on a temporary basis, warily stating that he would accept no salary.

Once more there began to move the melancholy procession of house surgeons. Dr Doyle (who was to die of typhoid in Melbourne three years later) was followed by Dr B. Moorhouse, Dr Porter and Dr Bancroft, all for very short periods. In 1886 Dr Westenra arrived in Christchurch fresh from England. His father who was chairman of the House Committee retired while the rest of the committee selected Dr Westenra

as house surgeon at a guinea a day. After the appointment Mr Westenra retired from the House Committee. Dr Westenra was young, energetic and full of English ideas. He forced the Board to many innovations but after three years fell from grace by admitting a case of venereal disease. Though the man was very ill the Board considered that the major issue was moral and not medical. It quoted the bylaw and issued a reprimand. Dr Westenra quoted his version of the Hippocratic oath, enclosed his resignation and departed for private practice. Dr de Renzi succeeded him. He was an energetic surgeon whose interest in the hospital was such that it eventually landed him in gaol. He resigned in 1892 and Dr Murray Aynsley became the new house surgeon. He had considerable ability and was examiner in pathology at Otago University despite the Board's reluctance to grant him leave. His chief contribution was his organisation of the nursing staff. He was in office when the famous enquiry into hospital activities took place in 1895. As a result of this enquiry an assistant house surgeon was appointed in the person of Dr P. Clennell Fenwick. He resigned in a few months and was replaced by Dr R. A. Fox.

The matron appointed by the new Board in 1885 was Miss Paton. She was the first trained nurse on the hospital staff. Her successors were Miss Boys (1888), Miss Steele (1890), Miss Maude (1893), Miss Johnson (1897), and Miss Ewart (1897). They were not happy women. They spanned that difficult period of transition between the untrained and the trained nurse. Each in turn tried to command her little band of nurses. The Board having given Miss Paton the right to make her own rules denied her the authority to enforce them. She could appoint probationers provided the House Committee first agreed. The dispenser could order his drugs only if the House Committee approved the list. Though the matron was supposed to control the female staff and the secretary the stores and the house surgeon the patients yet the Board controlled them all, watched persistently for any abuse of privilege, had no recognised channel of approach and at any suggestion of friction interfered arbitrarily at any level it chose.

Thus in 1886 the matron directed the porters to scrub the floors on Saturday mornings. The house steward objected to

feminine interference with his men and ordered two housemaids ('both being strong') to do it instead. The Board arbitrated and gave the verdict to the house steward. The matron then reported that the house steward and the cook consulted longer than was necessary over the daily issue of the stores. The cook was summoned before the Committee, conducted her own defence and was exonerated. She then made charges against the undercook. The Board reprimanded both. Finally after many scenes the Board dismissed the cook. On the day of her departure the scullery boy went out to hire a cab for her and her box. He was away for ten minutes and was sternly reprimanded for leaving the hospital without a signed pass from the matron. The House Committee, matron and steward all gave conflicting orders to the scullery boy, the gatekeeper and the boiler man as to who should clean the boots. At the beginning of its career the Board ordered the matron, the house surgeon and the dispenser to dine together. The edict was withdrawn only after their third protest. The night watchman originated a rumour that a scandal would result if he revealed the nature of some of his nocturnal observations and he was summarily dismissed. The house steward reported the extravagance of the matron in the matter of tea and the matron was reprimanded and put on a ration. The house surgeon protested that it was impossible to comply with the bylaw that no patient should stay in longer than a month as some of them were homeless invalids. The House Committee turned out eight such cases in 1890 but was forced to leave others. It then instructed the house surgeon to make the appropriate book entries whereby such cases were discharged and re-admitted on the last day of every month. The laundresses and wardsmaids complained that the matron's leave pass now demanded their return by 10 p.m. instead of the customary 11 p.m. The Committee informed the petitioners that it could not interfere with the matron's ruling and it informed the matron that she had to issue an 11 p.m. pass to anyone who wanted it. In 1886 Dr McGregor, Inspector of Hospitals, paid a surprise visit one Monday morning and followed this up with a scathing report on what he saw. He alleged dirt on the counterpanes and untidiness in kitchen and bedrooms. The matron was summoned

before the House Committee. She was equally critical of Dr McGregor for his lack of common decency in choosing such a time for a visit. She maintained the counterpanes were not dirty; they were merely faded and the alleged dirt was due to indelible medicine stains. All the matron got from the incident (beyond the usual reprimand) was an opportunity to go on pressing for new counterpanes. This she did and finally the Committee called for tenders for new ones. The best was that of Strange and Co. (7 ft. x 4 ft. at 6/9d. each). The Committee demanded a written guarantee from the vendors that the colours would not fade. Messrs Strange and Co. were not blind to the possible implications of this and offered instead the honour of their word. Whereupon the Board took one of the counterpanes, boiled it for a week, announced that it had survived the test and placed the order.

At times indeed the meetings of the House Committee bore a resemblance to a military orderly room so frequently were the various employees there in a defensive role. Often judgment was passed without the accused being given the right to speak in his own defence. Injustices were many and as time went by there was an increasing number in the community who harboured resentment against the Board. The resentment was not entirely for what they had done. Often enough it was for what they had not done. It was a very common practice to defer a difficult decision or an expensive proposal to a later meeting after which it was not heard of again. The disharmony in the hospital was also reflected in the honorary staff. An appointment gave a certain amount of prestige but very little else. Those appointed often attended without any enthusiasm, were reprimanded by the Board and frequently resigned. Even if they did not resign there was no security of tenure either for the honorary or stipendiary staff. Dr Bakewell while doing a locum for the house surgeon in 1883 had criticised him to the Board, and had been forced to resign. Later he had been re-appointed and when in 1886 he defended in the press the magistrate who had ordered an alcoholic into hospital he was promptly dismissed again.

The honorary staff elected annually was composed of two physicians, two surgeons and one ophthalmic surgeon. From

1885 till 1900 these positions were filled by the following in order of their appointment—Drs Guthrie, Frankish, Bakewell, Stewart, Symes, Moorhouse, Townend, Thomas, Anderson, Hacon, Ovenden, Deamer, Manning, Lomax-Smith, Meares, Mickle, Thomas, Murdoch, Nedwill, Boyd, Diamond, Bolger, Jennings, Fenwick, de Renzi, Thacker.

It was an age where opinions were positively held and vigorously expressed. For instance in 1892 the hospital was crowded and the staff was demanding beds. The Board, about to appeal to the public for funds for the nurses' home could not supply the beds. It asked why better use was not being made of wards 1 and 2 which had been expensively modified a few years before. The staff had its reasons and entrusted them to a deputation in the persons of Dr MacBean Stewart and Dr Lomax-Smith. The wards, said Dr Stewart, were to be condemned in the strongest terms. They were nothing but charnel houses. If they were modernised it was just possible that they might be used for outpatients and so need not be pulled down, Dr Lomax-Smith interrupted. He could not agree with his surgical colleague. The wards were impregnated with disease germs. They would remain so as long as they stood.

After this the Board had no alternative but to shut them up pending an investigation of the charge. It asked for a Royal Commission. The Government looked askance at placing some hypothetical germs on trial before such a weighty tribunal and sent Dr McGregor to inspect and report. He agreed that they were not wonderful wards, that they needed more ventilation and that if it were supplied they would serve for medical or chronic cases. He considered it 'absolutely absurd to close the wards referred to on the *ipse dixit* of one or two gentlemen whose conclusions as to their insanitary condition was based on such loose evidence'.

Whereupon the Board put in some hopper ventilators at 17/6d. each and reopened the wards. (The old ventilators were found to be stuffed with dead birds.) It was the most economical method of increasing the bed state that the hospital has ever known and completely defensible because in the meantime someone had been taking out statistics and had proved that sepsis in the maligned wards was less than in the modern ones.

CHAPTER EIGHT



The Evolution of the Nurse

THE FIRST MATRON IN THE CHRISTCHURCH HOSPITAL WAS Mrs Bunting whose qualifications were that she was the wife of the master. For the next twenty five years the qualifications were sometimes less than these. There was in fact little training that could be done. Asepsis was unknown. Personal hygiene was of a poor standard when the whole hospital had only one portable bath and the patients' clothes were stored under the bed. The nurses fetched and carried, lifted and shifted and were never expected to do more than to deal competently with medicines, enemas, poultices, plasters and stupes. They were in fact domestics who worked in the big house on the Avon instead of in a big house in Sydenham or the city.

It is true that they had a probationary period. Up to the nineties they graduated as nurses by first securing employment in the laundry or as a wardsmaid. Any good wardsmaid could be ordered to get up off her knees and by the time she had put away her bucket and brush she was a nurse. The Board would confirm the appointment at the next meeting. There were several instances of unsatisfactory nurses being transferred back to the laundry and occasionally a nurse was dismissed for drunkenness.

When the hospital opened in 1862 the total establishment of nurses was two. By 1880 the nursing staff had grown. There were four day nurses (£45 a year each) and four night nurses as well as three male nurses, two at night and one in the day. There was also Mr Brown, the male dresser (£100). Later in the same year, owing to the temporary closure of wards 1 and 2 the above eleven nurses were reduced to six. This left one

nurse to each ward on a twelve hour shift followed by the night nurse for a similar period. The night nurses were married men or women who lived at home but attended the hospital every second night for a fee of five shillings. They were merely night watchmen and each night nurse was therefore in charge of two wards. (Dr Wm. Irving reports that as late as 1897 when he acted for six months as assistant house surgeon no night operations were done during that period.)

The day nurses slept in the attics above wards 4 and 5. They ate in the ward kitchens or in their rooms. They had no official holidays, no uniforms, hard work, low pay, little knowledge and even less prestige. For these reasons they had small authority and male nurses were necessary at times to enforce discipline. Their very few privileges included a daily issue of a pint of beer or four ounces of brandy.

According to the bylaws any able patient could be called on to help the nurses. As a result all the ambulant patients assisted, usually without much persuasion. On one occasion a woman patient was pressed into service in an emergency and remained so long after recovery that her status became obscure. She then developed the habit of going out in the afternoon and coming back late, drunk and violent. The house surgeon discharged her as a patient but she preferred to regard the incident as the dismissal of a nurse without the usual week's notice. She claimed a week's wages and the Board paid. On another occasion a man with erysipelas had to be treated in isolation. A male patient was appointed to 'special' his colleague. After a preliminary inspection he indignantly left the hospital with the comment that he would 'sooner go and look for work'. The Board immediately replaced him with an inmate from the Armagh Street Depot who could not afford to be so independent.

It was recognised early in hospital development that any reform of nurses would have to start with the matron. In 1885 therefore the first trained nurse was appointed in the person of the new matron, Miss Paton, who had had two years' nursing experience at St Saviour's Hospital, London. The Board allowed her to make her own rules, and guaranteed support. Miss Paton persuaded the Board to agree to each new nurse

being supplied in the first instance with 'suitable dress material so as to appear in uniform attire'. The wardsmen were also to be supplied with a dark serge jacket and on the left arm a white band with a red maltese cross. Miss Paton next wanted an annual holiday for nurses. The Board said this was impossible and wanted to know how it could be done. The house surgeon firmly maintained that it could be done by employing another nurse to act as a more or less permanent locum for the holidaying nurses. The Board gave way and on August 30 1886, consented to the nurses having a fortnight's annual holiday.

In other respects Miss Paton was not so successful. She could not establish happy relations with the cook, the assistant cook and the domestic staff. She resigned in 1888 and was succeeded by Miss Boys.

The status of the nurse at this time was shown by an incident in 1889. Miss Boys went on holiday and Miss Buckley, who was quite untrained, replaced her for a few energetic weeks during which she dismissed several nurses. On the return of Miss Boys, Miss Buckley applied to the Board for the right to stay on in hospital (unpaid) for a month 'in order to learn nursing'. The Board hesitated but finally agreed. Miss Boys, thereby entrusted with the training of Miss Buckley, decided that the training would be thorough and set her to scrubbing floors. Miss Buckley objected and carried her objection to the Board which upheld it. The Board intimated in effect that it was prepared to grant her a pass in scrubbing and that she might now aspire to higher branches of nursing. It also paid her for the month she had acted as matron (£8/6/8). Later Miss Buckley applied for the position of nurse in charge of the ward. The Board promised to consider this if and when a vacancy arose. With an eye to the future Miss Buckley then asked for the right to stay in hospital for another month in order to learn nursing (honorary). The Board agreed (honorary).

The incident however focussed attention on the scrubbing of floors by nurses and in December 1889 this duty was fully taken over by the wardsmen, more of whom had to be employed. They lived out, got their breakfast at the hospital and were paid half a crown a day.

In the late eighties and in the nineties an occasional trained nurse from the United Kingdom secured a hospital appointment. One of these (Nurse Helen Dickson) included with her application a testimonial from Sir James Simpson of Edinburgh.

Miss Boys resigned in 1890 and Miss Steele was appointed. In her short reign the real steady reform of nursing began. Dr McGregor, the Inspector-General, had more than once in his annual report to the Government criticised the Christchurch nurses. They were 'the wrong type'. He wanted a higher standard of education, a better knowledge of medicine and a greater dignity of status. This meant in those days that nurses had to be drawn from a higher social class. The Board was aware of this and encouraged by the matron and the house surgeon altered the method of recruiting. It advertised in the papers for probationer nurses. The applicants were first interviewed by the matron and then final selection was made by the Board. They were to be called junior probationers and were on three months' trial without pay. This marked the end of the old free and easy days of nursing which were often bad and the substitution of discipline for the sake of discipline which was often worse. For instance up to 1891 the night nurses worked from 5 p.m. till 7 a.m. and then after breakfast fell into bed. Miss Steele forbade this. After breakfast the night nurses must spend a further two hours in exercise before they could retire. This was necessary to 'rid the system of deleterious matter'. The nurses, backed by an indignant medical staff, sent a deputation to the Board which referred them to the hospital committee which in turn, after a quiet word with the matron, sent them off to bed.

Various titles were applied to various nurses at different times, but by 1893 the English system was adopted whereby the orders were junior probationer, senior probationer (£7 per annum), nurse (£25), and sister (£35). The first sister in the hospital was Sister Knight, the Board approving the house surgeon's stated intention of using this title provided it involved no extra expense.

In 1891 the house surgeon (Dr de Renzi) began formal classes of instruction for nurses. A syllabus was laid down for

a two year course and nurses had to pass two examinations before they could qualify. The matron lectured once a month on the art of nursing, and later, at the demand of the Board, once a fortnight. The chairman of the Board offered a gold medal to the first trained nurse but as he shortly ceased to be a Board member no more was heard of it. The Board decided to present certificates instead of medals. At the presentation of the first certificates by the chairman of the Board after a Board meeting the matron deliberately absented herself.

This was an indication of the difficulties of the transition period. A different type of girl began to look on nursing as more of a career than an occupation. The rapidly increasing prestige of nursing in England, the tradition of Florence Nightingale, the establishment of a regular course of training with a qualification at the end attracted many young girls eager to learn and keen to work. When they arrived in hospital however they were not welcomed by their seniors who became apprehensive of their own future and conscious of their ignorance. The newcomers were referred to by one old nurse as 'broken down gentlewomen'. 'Lecture to them?' said another indignantly, 'I'll lecture them!' The veterans were poorly educated and instead of organised professional knowledge they had a shrewd clinical sense born of vast experience and so could instruct the juniors only by example. They also in general had hearts of gold and they were probably more highly regarded by the patients than were some of the smart young juniors who before long were babbling about the bones of the skeleton and the mechanics of respiration and circulation. It has been the privilege of the present writer to discuss this period with some of the few remaining trainees of those days. They admitted that though they were prone to criticise in their seniors the lack of graces, the limited vocabulary, the elusiveness of the aspirate, the rejection of the newer knowledge, yet they held them in high respect and through the years as the old have gone and the young have mellowed, the respect has increased.

But it was not seen as such at that time by the public and the new order of nursing precipitated a great deal of class feeling. Reference will be made later to Nurse Cameron and

her treatment by the Board and the public meeting that rallied to her support. It was felt by many that a privileged class of nurse was being created for the benefit of those who could afford to educate their daughters and that a method of living was being denied girls of a humbler class. But the report of the Commission in 1895 came down heavily on the side of reform and was emphatic that some of the older nurses should go. And go they did, quietly and unobtrusively with the way eased for them. Only wardsman Brown was dismissed peremptorily.

The new order of course made new demands. One of them concerned uniforms. The Board thought it had settled this in 1886 by providing £50 every year to dress all the nurses—the Board itself deciding on the material which was a heavy dark blue stuff like serge. In 1896 the matron asked for the nurses to be supplied with washable material. The Board deferred consideration of this as the new materials for the year had just been issued. The next year the matron brought the matter up again, and the Board realising that a fixed sum for an expanding nursing service (there were 38 nurses in 1897) was not very practical, decided to issue each nurse with a new uniform each year. But, it added, of the same material.

At this stage the nurses themselves made history by sending a direct deputation to the Board complaining of the unsuitability of the uniforms. Though polite, the male Board was untouched by the feminine reasons until the nurses played their trump card. Five cheap cotton uniforms could be bought for the price of one of the present ones. Instantly the Board was alert, sensing a bargain. Then it discovered that the new uniforms would need washing. It made a mental assessment of the cost of heating water and irons, providing soap and facilities for drying and found five uniforms for one was no bargain at all. The deputation failed.

The eight hour day was approved in 1895. The Board was sceptical of its practicability and referred the matter to the honorary staff which was so emphatically in its favour that the Board agreed. It was one thing to introduce it, but another to enforce it. It has in fact never been fully enforced yet. It is a proud tradition of nurses that if there is urgent work to be

done they do it. In 1897 the matron informed the Board of a nurse who had been spending twelve hours a day on diphtheria cases. This practice, said the Board firmly, must stop. How? asked the matron. The Board countered this awkward question by approving a motion that while the eight hour day must be rigidly enforced the house surgeon and the matron might be empowered to use their discretion.

Training in invalid cooking was a much discussed subject, the nurses being keen to learn. The Board after much hesitation approved under certain conditions—that only senior nurses be allowed to participate and that each had to pay a fee of ten shillings to the Board out of her own pocket.

In 1893 Miss Maude was appointed matron. She was English trained and had a clear vision of what nursing could be. She therefore was a strong supporter of all reform but at the same time was essentially practical and had the difficult task of inspiring her young trainees and placating her old nurses who were tireless in their rough and ready devotion to work that had to be done. There is clear evidence that Miss Maude was not happy in hospital and when she resigned in 1896 to found the District Nursing Service she had made the choice in her own mind of the practical side of nursing rather than the academic. She was succeeded in 1897 by Miss Johnson of Melbourne who was successful among twenty four applicants. She was not only matron but housekeeper, the new post being one that the recent Commission had strongly recommended.

One who was largely responsible for nursing reform was the house surgeon, Dr Murray Aynsley. Though he eventually left after a dispute with the Board the latter recorded in the minutes its special appreciation of the great improvement he had effected in nursing. The Board in fact was enthusiastic about better nursing but was loth to delegate any of its powers to the matron or the house surgeon. Hence the Board had to approve all the junior probationers and it appointed all the ward sisters. When Miss Johnson resigned in 1898 Miss Ewart who was a ward sister became acting matron until Miss Payne was appointed. When she resigned a few months later

Miss Ewart was again acting matron and was eventually confirmed in that position where she remained until 1908.

But although the nursing reforms took place with a speed that almost made it a revolution, it was only by a slower evolutionary process that public opinion finally approved of the change. The new nurses often entered the hospital against the wishes of their parents. (They had to be twenty one or have their parents' consent.) Their youth and smartness was frequently viewed with suspicion by the patients. The old bachelor who had lived his life remote in the backblocks was embarrassed by the attentions of the young nurses. One such patient in ward 6 complained to the Board that his nurse had shown more zeal for her task than for his susceptibilities. The Board then framed one of its ponderous resolutions: 'In future no sister or nurse shall be required to dress or deal in any way with bladder cases or in any case involving the exposure or handling of the male organ except in extreme emergencies unless she shall have signified in writing to the house surgeon and matron her desire to become competent to dress such cases.'

This enactment in its latter clauses foreshadowed a time when the male dresser or wardsman would no longer be available. Up till the end of the century they were an integral part of the nursing service. They were called dressers and were responsible mainly for first aid. They had little qualifications except that skill which is born of empiricism and long experience. Like the old time nurses they were doomed to go and for fifty years remained in an obscurity from which they are now timidly emerging.

With one exception not much is known about the male dressers of the early Christchurch hospital. Dr Fenwick refers to one in 1895 whose only qualifications were 'a kindly manner and a strong Scots accent'. At various times they were dismissed by the Board but this did not necessarily imply incompetence or misconduct. They were rarely the subject of any complaint and presumably were on the whole, good people who did a good job. One dying patient made a will leaving all his real and personal property to the dresser who received (after the Board had deducted the fees) approximately £5.

The exception was Wardsman Brown. He was appointed in 1872 on the basis of having had medical experience in the Crimean War and remained till his dismissal in 1896. He persisted through the comings and goings of house surgeons, matrons and Boards until he became a hospital legend. Repeatedly references were made through the years to his efficiency and though he was commonly known as 'Butcher Brown' the title was not necessarily vindictive. In those days when wounds healed mainly by second intention the daily dressing was an important aspect of treatment and this (in the male wards only) was part of his job. When an accident case was admitted and the accident bell rang through the hospital he was among the first on the spot. He attended at all operations and in the wards did minor operations himself. There are still a few people living who remember his squat figure as he stamped down the corridor often accompanied by his bulldog. In 1961 a Christchurch resident could recall the occasion when as a boy he was admitted with a compound fracture of the lower leg. An immediate amputation was performed by Brown. Inevitably as time went by he had critics. The confidence in him by some patients was such that he had a quiet unofficial practice outside hospital and occasionally an indignant member of the B.M.A. would report to a meeting that on visiting one of his patients he had found Brown massaging a shoulder or dressing a leg.

A man of poor intelligence was once admitted without any accompanying letter and the honorary physician noting an abnormality of the heart assumed this was the cause of the admission. He ultimately discharged the patient who went home and complained to his son that he was no better. That evening the son called in Brown who aspirated a collection of fluid from the testicular region (hydrocele) to the patient's great relief. The son then wrote to the Board demanding damages for negligent treatment. The Board censured the physician for his lack of efficiency, censured Brown for his excess of efficiency, and rejected the claim for damages. He severed his connection with the hospital as a result of the Commission of 1895. The Commission, keen to pave the way for a new order, had recommended various discharges and had particu-

larly mentioned Brown who in his old age had begun to think himself indispensable. He was invited to send in his resignation. He then established a tobacconist's shop next to Mason Struthers where he exhibited in his window the bullet-pierced skull of the patient to whom he had promised tobacco for the rest of the patient's life if he (Brown) could have the skull after death. A strange contract faithfully kept by both parties.

More nurses necessitated more accommodation. The Board placed six in the top storey of ward 3, the squat isolation ward surrounded by a high fence on the other side of which were the piggeries. But this was no answer to the inevitable expansion of the nursing staff and no preparation for the urgency of an epidemic. In 1891 the Board decided that nothing less than a nurses' home would do. Dunedin had a nurses' home, why not Christchurch? Photos of the Dunedin home were procured and Mr Maddison was asked to draw up plans for a similar model. The first suggestion to pull down wards 1 and 2, erect a nurses' home there and build a new ward elsewhere was soon dropped. The next choice was a site between the hospital and the river, or failing this at the boundary of the hospital corner where in fact the home was later built. But the river site was determined on and the Board launched a public appeal for funds. The immediate response was good, many country donations being received, from freezing works, saw-mills and industrial institutions. But after a year subscriptions fell off. This was largely because a certain section of the public had more sympathy with the nurses than with the Board which was shortly to be on trial before the Commission of 1895. The old cry of 'Hands off Hagley Park' was again heard. Some contributors to the fund wrote asking for their names to be deleted if the river site was selected. The architect pointed out that the sewerage pipes from such a building would have to leave seven feet above the ground to get the right fall to the sewer. A minority of the Board made two determined attempts to get the site changed. But the Board pressed on. It transpired that a special act of Parliament would be necessary to give the right to build on this site. A bill was prepared and the Hon. Pember Reeves pushed it through both houses in one session and it became law at the end of 1893. At the same

time a new Board was elected and its first act was to reverse the decision about the site, and to select the alternative. Strong advocates of the change were Messrs Perryman, Dunlop and Widdowson. Wellington, which had agreed to the first site, was equally complacent over the second. The Board considered the £934 it had collected and reopened the subscription lists. This time there was more enthusiasm. Public entertainments were given, a large fete was held in the hospital grounds, the public were invited to inspect S.S. Gothic at Lyttelton and the proceeds given to the fund which before long had reached £1800. This carried an equal Government subsidy. The Government had also at an earlier stage agreed to subscribe £500 and though later reluctant was firmly held to its promise.

Tenders were therefore called and ten were submitted. The lowest price however was too high and the plans were altered. Eight rooms were eliminated. Slate was to be used on the roof. The concrete foundations were to be lowered by six inches. The 'cellar' was replaced by a trapdoor in the main corridor so that a cellar could be built later. The linen room was to be divided into two bedrooms each containing two beds. Two lavatory basins on each floor were to replace the original three (thus saving £2 10s. on each floor). Home Bush bricks were to be used. On this basis the Board called for fresh tenders from the three who had submitted the previous lowest tenders, ignored the protests of the other seven and on March 9 1894 signed a contract with Mr Bower (who was shortly to build the Hyman Marks ward) for £3695.

The contractor had trouble at the outset with treacherous foundations and much extra concrete had to be used. Apart from this the work progressed speedily and the first nurses were in occupation by May 1895. The Board insured the new building for £3900.

By the end of the century then there was a systematic method of training nurses at Christchurch. Probationers were admitted at regular intervals in groups. They were uniformed and housed and treated with some of the dignity of members of a profession.

Their period of training was now extended to three years and included instruction from the house surgeon and the

matron and examinations from members of the honorary staff. On completion of the course they were given a certificate signed by their instructors and examiners. By these measures the Board had created something which it could direct but not control for by now the nurses were an organised group. In 1891 they held their first ball in the Art Gallery. They asked for a tennis court in 1894 and the Board agreed provided that the nurses paid for it. They raised again, though unsuccessfully, the matter of uniforms, but more important was the fact that they earned the approval of Dr McGregor and his assistant, Mrs Grace Neill, and through them the patronage of Wellington. In 1901 the Nurses' Registration Act was passed. It had been drafted primarily by Mrs Neill and provided for standard training and examination and was the first sole nurses' registration act in the world. Thereafter the Board lost much of its control over nurses and was frequently in conflict with Wellington over nursing matters. In his annual report of 1901 Dr McGregor referred to 'the unjustifiable interference of hospital trustees in the selection of probationers and the promotion of nurses'.

Despite this the North Canterbury Board in 1905 re-affirmed its policy of appointing sisters by seniority, abolishing the position of assistant matron (re-instituted in 1907) and refused to adopt Mrs Neill's suggestion of raising the sisters' salaries to £50 a year. The Board however was proud of the nurses. In 1903 it commented on the fact that the matron of every hospital in the South Island with one exception had been trained in the Christchurch Hospital. This approval apparently carried over into the next year because when the honorary staff wrote in and said that the old blue serge uniform was ridiculous and should be replaced by a lighter washable material the Board unanimously agreed. In 1906 Dr Jennings, in charge of the sanitary exhibits at the New Zealand International Exhibition held in Hagley Park waited on the Board and asked if it would like space to illustrate the workings of the hospital. The Board was puzzled and asked how it might be done. Dr Jennings suggested a little tableau of a hospital bed made up and two uniformed nurses standing beside it. The Board took the view that two nurses standing idly by a bed might please the

public but it never had and never would please the Board. The hospital was not represented in the Exhibition.

By 1905 there were forty nurses and more were urgently needed. Then, as now, nurses came, trained and went. Marriage absorbed most but many left for private nursing. In 1907 the Board seriously considered making the course of training four years but it was felt that though this might delay the resignation it might prejudice the admission. Instead the Board increased the salaries. A ward sister was to get £60 a year rising by £5 annually to £70. Staff nurses starting at £40 rose by the same increments to £50. Nurses in training were to get £25, and junior nurses £12. Probationers received no salary.

In 1907 the nurses' home was enlarged by means of the small wing which now extends as far as the Riccarton Avenue frontage (Mr R. H. Rankin £2198) and an engineering project of heating the whole home by means of steam radiators was commenced and finished in 1909.

The amalgamation of hospital and charitable aid activities under the control of the one Board in 1910 and the subsequent expansion of wards added urgency to the matter of nurses' accommodation. The Board suggested putting two more storeys on the nurses' home but the architects would not approve. It was then decided to build a new home, joining the previous one at an acute angle. This is the present building which flanks the junction of Oxford Terrace and Riccarton Avenue. It has always been known as an extension of the nurses' home, but architecturally it was a new building.

The contract was let to W. Greig and Son for £6401. The erection was without incident and the premises were opened in 1911. There was no delay in occupancy. About twenty nurses had been temporarily accommodated in the Medical Superintendent's house and others were scattered about the hospital. The new building provided seventeen bedrooms and the matron's suite on the ground floor. On the next storey were the submatron's quarters and nineteen bedrooms with a further nineteen on the top floor.

Thereafter no further accommodation was provided for nurses until the new home was built twenty years later.

CHAPTER NINE



Trouble in the Nineties

THE BOARD OF 1885, A LITTLE HEADY OVER THE ROCKLIKE solidity of its legislative foundations, pledged itself to a rigid control of the hospital confident that its administrative ability had, like its election, been decided by the ballot box. It had its sails set for a steady voyage. The ratepayers had to yield by compulsion and the Board could spend more or less where the whim might lead. The doctors had been knocked into shape, the patients were in effect denied the right to criticise because they were the recipients of charity. For every staff vacancy there were half a dozen applicants. There was no need for loyalty when discipline would do. There were in fact no rocks ahead.

There were, however, storm clouds gathering. The stability of the Board could persist only as long as the public would tolerate it and though the Board at times trailed a thin bait for public popularity there were no nibbles. Freedom in those days was a more sharply defined value than at present when national threats and the complications of a complex society make communal control essential. There was constant irritation over the levies and everlasting criticism of their expenditure with each allegation of parsimony being countered by one of profligacy.

Public opinion which is always more prone to drive direct at the charge and the verdict than to explore the evidence undoubtedly blamed the Hospital Board for much that was done by the Charitable Aid Board. It was not clear to many of the public that the two Boards were separate. The Charitable Aid Board was much more vulnerable. Its story, long and

complicated, cannot be told here, but for the last fifteen years of the century it was struggling with an enormous burden of outdoor relief as well as managing the new Jubilee Home, the old men's home at Ashburton, the Armagh Street Depot, the Female Refuge (later Essex Home), the Orphanage, and was allied with other organisations in certain projects of charitable aid. Viewed by present day standards its record was poor and was considered so even at the time. The public hammered away at it and in 1894 forced the Government to hold a commission of enquiry. The Board did not come out of it very well but better than the public thought was justified. Much resentment still lingered and was easily deflected to the Charitable Aid Board's minor accessory in crime, the Hospital Board. Public animosity towards the Board began to build up to a pressure that should have warned prudent pacifists to take off for safer fields.

The eruption was touched off in 1894 by an anonymous writer in *The Star* who aptly signed himself 'Tongariro'. The letter charged the hospital authorities with gross mismanagement, bad food, compulsory church services, bread and water for difficult patients, crudity by the dresser (Brown), cruelty to and by the nurses, discrimination by religion, incompetence of the house steward . . . There were eighteen charges in all. They were so specified and so recriminatory that it would seem that the author was either manufacturing them out of pure malice or had inside knowledge of a vicious state of affairs. Without hesitation the public accepted the latter explanation. The correspondence columns of the paper exploded into violent abuse of the Board. Supporting editorials were published. It became obvious that a large section of the public was implacably hostile.

No one on the Board seemed to recognise the ominous note in the public outcry and for a time it was ignored but this became increasingly difficult and at last Mr C. M. Gray opened up the whole matter at a Board meeting.

Mr Gray was the rebel against conformity on the Board. He was a retail draper, vigorous and energetic, a staunch teetotaler and one time Mayor of Christchurch. He was fearless in his opinions and usually in the minority. In the hospital

records there are dozens of references where the phrase occurs —‘The motion was passed, Mr Gray dissenting’.

But on this occasion the Board did not dissent from Mr Gray. It faced the fact that though as a Board it should be universally popular apparently it was not and the quickest way to lay the criticism would be to ask Dr McGregor to hold an enquiry. It then appointed Dr MacBean Stewart to the honorary consulting staff and closed the meeting.

There was an irony in this that was not appreciated at the time. Dr Stewart was a picturesque surgeon whose conflict with Dr Nedwill has already been mentioned. He had come under severe criticism from his colleagues at times both for his unorthodox surgery and for the fact that he had patented an asthma cure which he was openly advertising and selling. But he had many friends including some Board members. He had just retired from the hospital after twelve years’ service and some of the older nurses had presented him with a testimonial —and were reproved, not for the presentation but for using the Board room without permission.

Dr McGregor, who visited the hospital too frequently to be ignorant of what was going on and who was a canny Scot, found himself too busy. He handed over the enquiry to his assistant, Mrs Grace Neill, who soon arrived and set to work. Her terms of reference were of the vaguest. She had an ill-defined mission from Dr McGregor who was under pressure from a Board which was getting apprehensive about the public which was getting excited because an unknown person had written a letter to a paper. Great woman as Mrs Neill was, she was not the personality to wield any flaming sword of justice. She conducted her enquiries as a detective would, listening to all who would talk and eventually arriving at certain conclusions about certain people whom she had not consulted at all and who often had not had an opportunity of speaking in their own defence. She eventually reported to Dr McGregor and he sent a copy to the Board.

On the surface there was nothing very devastating about it. No one was whitewashed nor was any one specially convicted. The report maintained that there was less harmony on the staff than there should be. The main cause of this was the arrogance

of some of the older nurses. Now that the nurses' home was building it was time to dispense with some of the untrained nurses and attract a better type. This was a thesis that had long been maintained by Dr McGregor.

The Board, now quite confident that it was exonerated, continued with the building of the nurses' home. And as a gesture to Dr McGregor it dismissed Nurse Cameron, who at the enquiry had been accused of harshness and neglect towards patients. She protested but the protest was rejected.

Then the storm broke. A public meeting was called on April 8 1895. The Oddfellows' Hall overflowed. Mr G. J. Smith M.H.R. was in the chair. The meeting, like all meetings attended by angry people, was noisy and prejudiced. It was bitterly hostile to the Board. At the meeting any reference to Dr McGregor, Mrs Neill or the Board was greeted with boos and groans while any reference to Mr Gray evoked prolonged cheering.

The main talking point of the meeting was Nurse Cameron. It transpired that after eight years' service at the hospital she had gone on leave and while away had received a letter from the matron (Miss Maude) stating that the charges against her had been proved and that she was dismissed. A further letter advised her not to return to hospital. She had been denied a hearing by Mrs Neill, her witnesses had not been called and her lawyer had been excluded. The charges of incivility and carelessness against her had been itemised and the patients named. Five of these had since died and almost all the others recorded in writing their refutation of the accusations. An even less biased body than the public meeting would have agreed that Nurse Cameron had had shabby treatment. More sinister was the fact that Dr McGregor had not recommended her dismissal but that she and some others should be transferred to the Lock ward (venereal disease) which he understood the Board was about to start. The Board however had no intention of starting a Lock ward.

All this lost nothing in the telling at the meeting. There was scant sympathy among the pioneers of the trade unions for Dr McGregor's privileged class of educated nurses. Only the wealthy could afford education. The sole requirement for a

nurse, claimed some of the speakers, was to have a wealthy father. These were the same people who sat on the Hospital Board (Shame!). Why should this exclusive right be given to these Tories? (Groans). Everyone knew the splendid record of the present nurses. (Prolonged cheering).

In the end the meeting almost strangled itself in its own lack of opposition. A lengthy motion expressing no confidence in the Board and calling for a new and judicial enquiry was moved by Mr G. W. Russell and seconded by Mr T. E. Taylor and carried thunderously by the rest. The meeting then proceeded to frame another motion calling on the Hon. W. Collins, Minister of Hospitals, to appoint a Royal Commission. Before this was completed someone asked why they should go and grovel before Mr Collins who after all was part of the pernicious hospital system that included hospital Boards, Dr McGregor, Mrs Neill and in fact everyone except Nurse Cameron (cheers). So the second motion was abandoned. The meeting contented itself with some further insults to the Board and then broke up.

A few days later a deputation waited on Mr Collins. It represented church organisations, trade unions and temperance societies. The meeting was orderly and dignified. Mr Collins was sympathetic and helpful. He pointed out however that Boards were ultimately elected by the people and that the Government was loth to intervene. The Government could hardly set up a Royal Commission at the request of a public meeting. It would be a different matter if the request came from the Board itself. He promised that he would not lose sight of the purpose of the deputation. He then wired urgently to Mr Seddon stressing the necessity of further investigation as Christchurch at the moment was seething. He then wrote to the Board, openly associating himself with the deputation and suggesting that as a Commission was now almost inevitable it would perhaps be wise if the Board asked for it.

The Board, unhappy and uneasy, held a special meeting. At earlier meetings it had made such disparaging comments on the uninformed public that the matter had now passed beyond the stage of conciliation. It particularly did not want a commission and it objected to being made the mouthpiece of the

public in asking for one. In the end it compromised by passing a motion that it would assist in any way possible any commission that might be set up.

The Commission was set up, with Dr Giles as commissioner. It was a judicial enquiry with evidence given on oath and various counsel representing the involved parties. The Board was defended by its own solicitor, Mr Loughney. The first sensation was that the author of the defamatory Tongariro letter was revealed to be Dr MacBean Stewart. It became clear that the whole affair was inspired more by personalities than by policies. Dr Murray Aynsley was championing a new and better type of nurse. The older type found their champion in Dr Stewart and had presented their testimonial.

Dr Giles dealt with all the eighteen charges in turn. The evidence was long, tedious and sometimes contradictory. There was an answer to all the charges, some of the answers being more satisfying than others. Eventually Dr Giles presented his report. It dealt faithfully with every issue raised and though it took more than 13,000 words it was praised in the *Lyttelton Times* for its conciseness.

After all the fuss there was nothing in the report that was cataclysmic. It described the Board as 'weak kneed' but admitted the Board's difficulties and refused to recognise the members as the inhuman monsters of the press correspondents. It then proceeded to topple some of the bulwarks of the Board's enactments. Certain of the old nurses should go—kindly and painlessly if possible because their main fault was that they belonged to an era that was now passing. Wardsman Brown must depart in the interests of harmony. Probationer nurses were to attend certain operations on males only if they so wished. (It was to such that Brown had said 'You may become women but you'll never become ladies'). The eight hour day for nurses should be enforced. (The Board had approved it but had not provided enough nurses to make it practicable.) Pauper funerals should be abolished. (The Board had a contract with Mr Barrell for 15/- a funeral.) The food should be of better quality and the serving of it should be better organised. A housekeeper should be appointed. (The secretary acted as housekeeper.) Compulsory church services

in wards should be abolished. The rules for admission of cases were too rigid and for the distribution of stimulants (a misnomer for alcohol) too lax. A number of the charges—that certain patients were put on bread and water, that the house surgeon did secret operations, that probationers were accepted only if they belonged to the Church of England etc.—were all rejected as false.

There was little in the report to comfort the Board. It received the report and made some attempt to implement its findings. It appointed a housekeeper at £52 a year. (The following year when the noise was subsiding she was dismissed and the duties given to the matron.) Mr Brown was allowed to send in his resignation and was given three months' pay, with Mr Gray, who favoured six months, dissenting. In his place Dr Fenwick was appointed at the same salary (£100 a year). The Board decided on the judicious dismissal of some of the older nurses. (Some equally judicious resignations solved this difficulty.)

What the Board did not do was to learn the lesson. It passed a motion threatening 'instant dismissal' if any nurse were proved guilty of 'tittle tattling outside the hospital'. It instructed the house surgeon to report any member of the staff who was not doing his duty properly. This evoked such a protest from the staff that the rule was modified whereby the report was to go instead to the chairman of the staff. Mr Loughney then presented his account for £1400, being his legal and witnesses' expenses. This was challenged, defended and paid, the *Lyttelton Times* and its correspondents objecting strongly to the ratepayers' money being used for such a purpose.

The ripples from a big splash take a long time to settle. Feeling had run so high during the enquiry that tensions on and between the Board and the staff remained. The staff wrote to the Board about Dr Stewart. For once the Board agreed and Dr Stewart's name was struck off the Honorary Consulting Staff, not even Mr Gray dissenting. This is the only occasion in the history of the hospital where this has been done during the lifetime of a member. It was however an empty triumph. At the municipal elections a few months later the

Borough of Christchurch returned Dr Stewart and Mr Gray as its representatives on the Board.

One of the first duties of this new Board was to elect the new honorary staff. Dr Deamer and Dr Murdoch were appointed physicians. Three surgeons applied for two vacancies—Dr Nedwill, Dr Lomax-Smith and Dr de Renzi. The last had given damaging evidence against the Board at the recent enquiry. The Board disposed of his application by a special motion—‘That the application of Dr de Renzi be not entertained’. This was in committee. It was alleged later that the chairman had made some defamatory remarks about Dr de Renzi. The next morning the chairman (Mr Thomas) received a phone message asking him to call at a certain business office. He went and on entering found himself confronted with Dr de Renzi and several others including wardsman Brown. In the conflict of evidence given later only one fact is clear and freely admitted by all parties, namely that Mr Thomas was knocked down by a blow delivered by Dr de Renzi. The assailant claimed that his sole purpose was to get a signed statement from Mr Thomas in which the latter’s statements of the previous day were to be repeated and that the blow was unpremeditated and was an unfortunate impulse. On the other hand Mr Thomas alleged that he was lured into a trap, that he was prevented from leaving, that he was challenged to fight and that two blows were struck. At the subsequent supreme court trial the judge, Mr Justice Denniston, stressed the conflict of evidence and even stated bluntly that Brown had committed perjury. Motives and methods aside there was no doubt of the one blow and the jury had to return a verdict of guilty though they added a strong recommendation to mercy. The sentence was one month’s imprisonment and in deference to the prisoner’s professional status he was excused the usual hard labour.

On this refinement of justice Christchurch immediately split into two camps. One group claimed that the sentence was absurdly light and that it was iniquitous to exclude the hard labour. What would the sentence have been if he had been a labourer? The sentence was vicious said the other group adding that hard labour would ruin a surgeon’s hands. Were a

surgeon's hands, asked the first group, of more importance than those of a watchmaker, a jeweller, a musician? Two of the jurymen wrote to the press stating that they fully expected that the recommendation to mercy would have ensured probation only and hinting that the verdict might otherwise have been different. Even the Judge was constrained to make a public statement in defence of the sentence. A petition praying for a remission of sentence began to circulate. In two days it collected 5500 signatures and was thrust into the reluctant hands of the Minister of Justice at the railway station as he was passing through Christchurch. He promised to forward it to the appropriate quarter. But the wheels of justice turn slowly and the wheels of politics more slowly still and a month is not long—for those who are free men. The sentence was served. Dr de Renzi returned and at the station received a tumultuous welcome from a large crowd of Christchurch citizens.

Meanwhile the Board, having deplored the whole incident, sympathised with the chairman, regretted that some traitor among them had revealed business conducted in committee, listened to the suspects declaring their innocence (including Dr Stewart who was hurt by the chairman's hesitation in believing him), settled down to work again. Almost immediately another battle flag was raised, this time by Dr Murdoch. He wrote to the House Committee stating that Dr Nedwill had amputated a man's leg, thus causing a permanent and unnecessary mutilation and had broken the bylaw that no major surgery should be done without prior consultation with all the staff. He refused to be associated with an institution where such practices persisted and he forwarded his resignation.

Dr Nedwill was surprisingly urbane over the whole matter but could hardly afford to be otherwise because he had once taken the same action when the same rule had been broken by Dr Stewart. He first justified the operation. The man was in intractable pain. 'I have blistered him, fired him, incised the periosteum and trephined the bone without doing him any good.' The man had begged for the amputation. After the operation he found a hopelessly diseased bone. The patient had been the subject of numerous informal consultations with

members of the staff. He had overlooked the necessity of a formal consultation with Dr Murdoch. He was quite willing to resign if the House Committee so desired.

The House Committee did not desire. As Mr Gray bluntly stated, it was now getting difficult to find men who would go on the staff. The Committee scolded Dr Nedwill, soothed Dr Murdoch, cited the virtues of friendship and requested Dr Murdoch to withdraw his resignation. Dr Murdoch refused to accede to the request of a House Committee. He might consider it he said if he were asked by the full Board. The full Board included Dr Stewart who for a long time had endured the gibes of Dr Nedwill for having once amputated a man's leg at the thigh for sciatica. By this time the personal motives were getting too tangled for there to be any profit in further analysis. The Board asked Dr Murdoch to withdraw his resignation and he complied.

For a month or two there was peace and then again the war drums began to throb, beaten this time by Dr Lomax-Smith. He charged the house surgeon with negligence and as a protest forwarded his resignation. The charges arose out of the division of duty between the house surgeon, Dr Murray Aynsley, and his assistant, Dr R. A. Fox (not to be confused with Dr Walter Fox) particularly over the question of responsibility for dressings after operations. The matters involved were highly technical and quite beyond the comprehension of the lay committee of investigation set up by the Board despite the defence that its personnel 'included two lawyers who were used to sifting evidence.' It conducted the enquiry in secret, heard some witnesses and refused to hear others. It found against Dr Murray Aynsley and asked for his resignation in three months. He gave it in one month. The appendix to his last report was an illuminating justification of his actions. The Board refused to receive it. Dr Fox resigned in protest. So did Dr Deamer. The staff asked for a copy of the evidence and was refused. Dr Murray Aynsley was championed by the B.M.A., given a farewell supper and the surplus funds (£10) to buy surgical instruments. Dr Lomax-Smith came back. Applications for a new house surgeon were called and Dr Walter Fox was appointed.

This marked the beginning of a new era. Dr Fox, grounded in integrity, benign or militant in the light of his conscience and a lover of humanity, was too massive a personality to stumble at the caprice of a Board. He could, and in fact did carry the war to the enemy's camp. Shortly after his appointment he had a difference with Dr Boyd and resigned. The usual enquiry was made by the House Committee, the affair was smoothed over and he was requested to withdraw his resignation. In 1898 the nurses' examiners reported that two candidates would never be able to pass and should be asked to resign. Dr Fox approved and so did the House Committee. The Board thought otherwise. It had never appointed a panel of examiners and was not to be bound by the opinion of this shadowy group. The nurses should get a further chance. This was decided in committee. On resuming the chairman, Mr Thomas, said he felt so strongly that the Board should have upheld the examiners that he intended to resign from the chairmanship and the Board. Attempts were made to dissuade him but without success. In the meantime Dr Fox, who had his own methods, forwarded the resignations of the two nurses.

Mr Gray was appointed chairman. A year later (1899) a special meeting of the Board was called to consider the impasse over the plastering of the Marks wards. A routine letter from Dr Fox had appended to it a protest against some of Mr Gray's criticisms. The Board took this seriously. Mr Gray temporarily vacated the chair in favour of Mr Douglas and then spoke in his own defence. Dr Fox was summoned and made his statement. The matron was called in and cross-examined. The three witnesses then retired. After a long discussion the Board passed a motion 'That in the opinion of this Board, for the good of the hospital, the Chairman be asked to resign that position, the Board being thoroughly satisfied with the house surgeon's explanation'. The motion may have had grammatical flaws but not even Mr Gray could detect any obscurity in its meaning. He resigned the chairmanship but remained on the Board, perpetually dissenting to the wish of the majority and devoting himself to trying to get the motion rescinded. His first attempt provoked a long discussion and failed. His second attempt failed after only a short discussion.

His third attempt was barely launched when the ominous motion was passed 'That the Board proceed to the next business'. Mr Gray was too experienced a political navigator not to recognise the way the winds were blowing. At the end of the year he did not seek re-election.

It would be wrong to assume from this melancholy tale that the Board did little except foment discord. They were bad Boards composed of good men. The members were honest and sincere, generous of time and effort and utterly conscientious in their duties. Their only faults were in their judgments. They were bound to the sacred trust of safeguarding public money and perpetuating the ordered system of society. They were not aware that around them mankind was once more massing for the march behind the banners of social change. They were the elect of various bodies but they were not the elect of the people. They would have rejected the opinion of the *Lyttelton Times* even as far back as 1866 when it examined the curious affair of Mr Andrews a labourer who was standing for the Provincial Government and decided that it 'was a good principle' that such bodies should have a representative of the working man. The bitterness of the public in 1895 was directed nominally against the Board members but the real conflict was with what they represented. The public wanted the rights of man; the Board was concerned with the rights of society. Thus they failed with their policies but were more successful with their projects.

CHAPTER TEN

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The Advent of Hyman Marks

THE BOARD IN 1885 HELD ITS FIRST THREE MEETINGS IN THE City Council chambers but thereafter established a Board room in the staff room (now the splint department). It could thus deal with hospital problems on the spot. Many minor improvements were thereby made. After the removal of the central fireplaces from wards 4 and 5 the wards were unheated for a period before the introduction of steam heating. But in the side rooms fireplaces were built (Tender, £20 each). At the time of writing the chimneys are still there, bricked up. After this, Dr McGregor referred to the three wards as 'patterns of comfort and freshness'. The wards were further improved by bedside lockers in 1889. In 1889 some wheeled chairs were purchased with £30 (and subsidy) given by the staff from the Destitute Patients' Fund. An attempt was made at treating the ward floors with linseed oil but it was not a success and the scrubbers resumed duty. Up to 1891 the wards were scrubbed six days a week. The House Committee reduced this to twice a week but after strong protests from the matron agreed to three scrubblings a week. Some attempts were made to deal with noise. The stairs leading to ward 1 were carpeted with leather. From 1880 linoleum (first invented in 1870) began to be used. When the floor of the corridor started to crumble an experiment was made with 'noiseless asphalt' (sixpence a square yard). Iron and zinc baths in the wards gradually replaced the marble ones, gaining in utility what they lost in appearance. Dr de Renzi asked for hot and cold water to be supplied to every bed in ward 6. He probably never expected it and possibly was satisfied when a year later he got two cold

water taps in both wards 4 and 6 for the irrigation of wounds. Miss Maude asked permission to place illuminated scripture texts on the walls between the beds. This was refused. A little later the house surgeon applied to place test tube racks for urinalysis in the same place. He succeeded. The old beds—described by Dr McGregor as ‘miserable and broken backed’—were given, along with the mattresses, to the Jubilee Home and new ones with springs were introduced in the hospital.

The outside of the hospital was not neglected. About 1897 the old creek in front of the hospital was filled in and a barrel drain running under the present engineer’s yard connected this area with the main drain on Riccarton Avenue. After the sewer was connected the Drainage Board charged the Hospital Board £25 a year for extra pumping. As the previous nightman had a contract of 16/- a year for each of his thirty six pans (total £28/16/-) the new arrangement showed a useful profit. A back entrance (now the main entrance) was formed in 1889 by putting up heavy gates. The sentry box near the main gates was removed in 1894 to make room for the nurses’ home. The hospital also had a fowl yard and pigsties and in 1895 a shed was built for the horses and vehicles of the honorary staff (£19). The pigs were before long convicted on an olfactory charge and after their removal their premises became a stable for the house surgeon. In 1889 the hospital was painted for £105. The tender of £70 was rejected, the Board agreeing that no such offer would be made by anyone of normal intelligence. In 1890 the sundial presented by the Mayor (Mr S. Manning) was erected on the lawn opposite ward 4, where it still stands in its ornamental isolation.

Progress in therapy was more marked in surgery than in medicine. It is impossible to put a date to the beginning of aseptic surgery in Christchurch. It slowly evolved from the idea of antisepsis and the various surgeons had different degrees of conviction at different times. In 1895 the Chairman of the Board in presenting his annual report referred in the most eulogistic terms to the aseptic technique which was in operation, not in the Christchurch hospital, but in the private hospital of Mrs T. Cochrane Brown at Strathmore, Ferry Road (now occupied by the Child Welfare Department) where Dr

Townend was superintendent. 'The public,' said Mr Moor, 'owe a debt of gratitude to Dr Townend for having introduced aseptic surgery for now that it has been introduced in Christchurch it is sure to be taken up elsewhere in the Colony.'

At the time Dr Townend was a member of the hospital staff and presumably he at least was practising the new technique. The rest of the staff probably listened with more interest than did the Board, which found in the chairman's report much of political and less of bacteriological interest. Mr C. M. Gray, that doughty opponent of unanimity, objected to the adoption of the report on the grounds that a eulogy on a private institution did not come within the scope of the Board and also that the chairman had stated the hospital was working harmoniously, which it was not. Mr Gray's protest and the subsequent quibbling of the Board before the report was adopted provided excellent publicity for the new technique.

With the introduction of asepsis, surgery expanded and the Board in the nineties found itself faced for the first time with a new expense—surgical instruments. In 1891 Dr de Renzi while in England spent £56 on surgical instruments for the hospital and was reimbursed by the Board. In 1892 the Board agreed to the purchase ('if absolutely necessary') of a bunsen cautery, twelve pressure forceps, a set of trocars and six dozen suture pins. The following year it refused a galvanic cautery but approved of catheters, bistouries, an inguinal truss and a set of dilators. In 1893 it bought twelve dozen clinical thermometers. (This was a difficult year because there was an unpleasant smell in the theatre which remained until 'the heating pipes were cleaned and rendered free of vermin'). Two incandescent gas lamps were fitted in 1894. But in 1896 the staff asked for a list of instruments costing £175. The Board protested. The staff persisted. The Board agreed but not very happily and withdrew the house surgeon's right to permit hospital instruments to be used for outside operations on payment of a lending fee. It would seem from this large purchase of instruments that surgeons were now out to explore new fields and that asepsis had removed some of the hazards.

Previously the fear of sepsis had sometimes been as great a problem as sepsis itself. In 1886 Dr Symes decided to operate

for the removal of an ovarian cyst. The operation was, in those days, a formidable one and had never been performed previously in Christchurch. The case attracted much interest and a good deal of publicity and the surgeon was certain to receive considerable praise or censure according to the outcome. For this reason Dr Symes rejected the Christchurch Hospital with its permeating contagion and petitioned the Board for the right to operate at the Sandhills (near the present Burwood site) in a small isolation building which had been erected for smallpox cases but had never been used. The Board, after some pressure, agreed. A special nurse, Mrs Bell, was engaged. Various items of hospital equipment were transported and one version of the story states that Dr Symes, dissatisfied with the operating table sent from the hospital, sawed the end off his own kitchen table and substituted the latter. Eventually all the preparations were complete and a cab was sent for the patient. It then transpired that the patient had been even more interested than the public in the doubtful result of the operation and had departed permanently for the North Island. The equipment sadly came back and Mrs Bell sent in an account to the Board naming £3/10/6 as her retaining fee. The Board paid and tried to forget the whole incident.

A miserable aspect of hospital administration in those days was the collection of fees. The truly indigent were treated free but the Board assumed that no patient was indigent until he had proved it. The patients (or their relatives) were well aware that if they were obdurate enough the claim would finally be waived. All patients were closely interrogated on admission as to their financial potentiality. This was the duty of the dispenser in 1885 but in 1889 the task was transferred to the secretary. Despite a punctilious few who counted it a matter of honour to pay to the limit of their means the patients' fees for years represented only ten per cent of the general expenses of the hospital. The Board never gave up the struggle easily and relied on debt collectors who lived precariously on ten per cent of their collections. When a patient was admitted from another hospital district the former charged the latter full fees. This often resulted in a lengthy argument as to the patient's legal domicile and sometimes if the evidence was not

clear, litigation resulted. Thus when the Grey Hospital Board persisted in ignoring the accounts for a patient in Christchurch Hospital the latter issued a summons against the Grey Hospital Board. It was returned marked 'No effects'. It was then recast with more penetrating legal power and reissued. The parties came before the magistrate and Canterbury secured judgment. Shortly after, however, the Auckland Board was successful in a similar judgment summons against the North Canterbury Board. It was all a silly business, costing in time, effort and money more than it ever produced in cash. The clerical staff—on the administrative side, for there was no clerical staff for clinical matters—was probably more conservative than any other department of the hospital, despite the introduction of the first typewriter in 1900. This was a mixed blessing. The annual balance sheet no longer had to be printed, the minutes were legible but the volume increased.

In 1887 there was enacted a piece of legislation which was to have far more important consequences than were realised at the time. This was the Christchurch Hospital Act which vested the hospital and the land in the Hospital Board, but restricted the use of two parcels of land totalling $1\frac{1}{2}$ acres comprising that area between the hospital and the river. The relevant portion of the Act read:

'The lands . . . are hereby vested in the (Hospital) Board in trust for the purposes of a kitchen garden and of pleasure gardens and recreation grounds respectively for the use of the inmates of the aforesaid hospital and for no other purposes and so that the said Board shall not at any time erect or permit to be erected any buildings or constructions of any kind thereon except such as may be approved by the Domain Board having the control of the lands in Hagley Park.'

It is this clause which has limited the façade of the hospital. Without it the present lawns might easily have been cluttered with buildings.

It will be seen from all this that the hospital was concentrating on making the best of what it had but was uneasily aware that it had not much. By the mid nineties there had been only

the second ward 3 added to the bed state in twenty years, and the hospital was overflowing. The staff and the Board in this instance agreed that another ward was necessary.

In more familiar terms what was needed was money. The Board had no reserves and no available security and no legal right to levy. It could not appeal to the public again as the public, spreading its enthusiasm thinly over some years, had just built the nurses' home. The Board decided therefore on the old stratagem of applying to the Government, having first secured the support of the local members of parliament. The Government agreed that new wards were necessary and brought down legislation whereby levies could be made for building purposes but parliament refused to pass this. The Government then offered the Board £1500. In terms of money this was something but in terms of building it was less. It could not be lifted till more was obtained and this seemed beyond the range even of ideas. The Board kept the subject alive by calling for competitive designs for a new ward.

In June 1895 the problem was dramatically solved when the will of the late Mr Hyman Marks was made public. Mr Marks had been born in Warsaw in 1840 and at a comparatively young age had come to Christchurch. He had first been a tobacconist in partnership with Mr B. Simpson in buildings that have now been replaced by Hallenstein's in High Street. He then became the proprietor of a boot shop and finally entered into the loan and discount business. In this he prospered. He had no family and he was concerned about his will. In his final illness he was intimately associated with his doctor (Dr Ovenden), his lawyer (Mr Kippenberger) and his nurse (Mrs Agnes Harper). It was through their representations that he chose the sick and needy for his philanthropy, the main beneficiaries being the hospital, the charitable aid, the mayor's coal and blanket fund.

The trustees, Messrs C. Louisson and A. Ferguson, advised that the Board's share was £5000 for the erection of a new ward while a similar sum was to be invested and the interest applied to the Destitute Patients' Fund. The Board's gratitude was qualified only by a doubt as to whether the gift invalidated the Government's promise of £1500. Apparently it did not and

the Government paid. Two wards were favoured. The site was obvious—west of ward 6 (the present site). The architects, Messrs Strouts and Ballantyne, prepared the plans and tenders were called.

Then began that long series of difficulties which marked this unhappy building enterprise. All the tenders were too high. The Board approached the Government again pointing out that a mere £1000 stood between an overcrowded hospital and two magnificent new wards. The request was peremptorily and almost indignantly refused. The Board then with some diffidence laid its problem before the trustees of the Marks estate. A further £500 was granted provided that the work carried the Government subsidy of 24/- (which it did) and that it was carried out during the winter months of unemployment. By all these means the Board then had £7600. Fresh tenders were called and that of Mr W. H. Bowen who had just completed the nurses' home was accepted for £7489. On September 12 1895 before a large public gathering the foundation stone was laid by Messrs Louisson and Ferguson. In the lengthy speeches there were two main themes—gratitude to the benefactor and gratification at having 50 new beds added to the crowded 116 that then comprised the hospital.

There was no reference to the fact that the contractor was having trouble with the site. Trial holes had been sunk and deep down was found a wooded swamp with unsound patches in the sand apparently caused by the roots of buried trees. A further £275 had to be found for establishing firm foundations but after this was done a rumour persisted that the foundations were still unstable. The Board consulted the architects who said the rumour was nonsense. 'The foundations would support thirty times the weight they would have to support.' The Government inspector of public works at Dunedin, Mr Ussher, was asked to confirm this. He visited, inspected, took back samples and eventually reported that the foundations were quite satisfactory.

A short peaceful interlude was then terminated by further rumours that the contractor was subletting portions of the building at cheap rates. This was disproved by the contractor who, bound by penalty clauses, pushed on against the obstacles

of slow delivery of the slates and baths from England and a variety of extras ordered by the architects. Eventually the work was completed, the architects' last certificate was given and the contractor applied for his final payment of £1785. The Board refused on two grounds. The plaster was defective and the penalty clauses for the delay in building entitled the Board to recover £680.

Then ensued the famous issue of the plaster. At an early stage of the plastering the Board had expressed doubts as to its quality. The architects repeatedly stated that it was perfectly satisfactory. It obviously was not. It developed cracks and unevenness and though parts were ripped out and replaced fresh imperfections kept appearing. The Board eventually refused to take over the wards. The architects insisted that there was nothing wrong while independent architects commissioned by the Board were equally emphatic that there was. Dr McGregor condemned the plaster in terms that were almost violent. The battle of the plaster became temporarily the battle of the architects and the Canterbury Society of Architects was dragged in. It suggested that all the contending parties should submit to arbitration and that the arbitrator should be Mr R. M. Beetham S.M. This proposal was agreed to by all parties.

The proceedings took place at the hospital and the wards were first inspected. The Board, the architects and the contractor were all represented by counsel. The evidence soon revealed that the Board had contributed to the delay and that penalty clauses could not be recovered. The main evidence was concerned with the plastering. Everyone agreed (with the exception of Messrs Strouts and Ballantyne who did not give evidence) that it was a poor job. The plasterer, Mr Andrews, said that in his experience of thirty years it was the worst that he had ever seen. He blamed the hydraulic lime and the cement that had been used. He had replastered much of it and thought that it was fairly satisfactory. Dr McGregor said that it could not be worse and from the point of view of harbouring germs was positively dangerous. Mr Whitelaw, Mr Jewell and Messrs Maddison and Collins, all architects, spoke disparagingly of the work. Technically it appeared that the materials were too 'fat'.

Mr Beetham gave a reserved decision. He exonerated the contractor who had fulfilled his task with the approval of the architects. The Board would have to pay.

This narrowed the field. The dispute was now between the architects and the Board. Sir Robert Stout was asked for an opinion and said the Board's only remedy was to allege negligence and refuse to pay the architects. The Board's solicitors, Messrs Loughney and Lane, concurred but were not optimistic. It was apparently a matter of the specifications and they had been too loosely drawn. The Board made a show of defiance but was forced to settle the architects' account. They were unhappy days for the Board. At the same time there was the interminable wrangle over the tank stands, trouble with the staff, public criticism and the full costs for the Marks wards with the plaster dropping off the walls.

The only point on which the Board was doggedly determined was that some architects were better than others and Mr Whitelaw took over. He suggested painting the existing plaster and experimenting first with two small rooms in ward 8. But Dr McGregor, though conceding the covering value of paint, insisted that the trouble was deeper. Parts of the plaster had broken from the laths. After many suggestions and counter suggestions Mr Whitelaw advised ripping it all out and starting again. Finally the Board compromised and Mr Andrews was paid £311 for replastering the worst parts.

It was a sorry dispute over a very technical problem because it was generally agreed that the fault was not in the workmanship but in the materials. There was much discussion about hydraulic lime and local cement and Keene cement. It was said at the time and has often been repeated that certain financially interested parties had insisted on using locally produced materials.

Long before this dusty conflict however the wards had been optimistically opened by the Governor General, Lord Ranfurly, on November 10, 1897. Even this ceremony had its defects. Because of limited accommodation only 220 persons were invited and certain public bodies such as Borough councils and the City council were not asked. Many of those invited failed to come and the Board had some difficulty in explain-

ing the vacant seats. Lady Ranfurly presented two oil paintings to the wards. Later the Duke and Duchess of Cornwall gave their autographed photos. Still later a private bequest of £11 carrying an equal subsidy was expended on pictures. All these now seem to have disappeared.

The official opening of the wards preceded their occupancy by two and a half years. One delay followed another. The floor boards were 'secret' nailed (£20). The wards had to be shut while the plaster dried. The builders had to stop while materials came from England. At a late stage the foundations were floated. The engineer had to modify the lift entrance. It was not till April 1900 that the first patients were admitted. Ward 7 was occupied by male surgical cases and ward 8 by female surgical cases though it was often referred to at the time as a children's ward. The small wards on both floors became ophthalmic wards and have continued as such ever since.

In 1907 the balcony on ward 8 and the verandah on ward 7 were constructed, using the Dwyer bequest for the purpose. The contract was secured by Mr A. Swanston for £689.

The only serious fire that has ever threatened the hospital occurred in ward 8. It broke out between the roof and the ceiling on the morning of February 26, 1908. The cause was never determined. Both roof and ceiling were destroyed and by the time the brigade had finished both wards were reduced to a shambles. All the patients were safely evacuated and disposed of in other parts, mainly in the old buildings and in ward 3.

There were certain consequences. The State Fire Insurance Company paid Mr J. Rowe £2673 for restoring the wards. The Board erected fire escapes in the old wards, the nurses' home, and ward 8. In the reconstruction of the wards a new electric lift was installed. (The original one was manipulated by hand.) Ward 8 has now had three lifts—the two above and the last in 1957. The renovation of the wards took nearly nine months.

Many years later Mr Ferguson asked the Board to accept a marble bust of Mr Marks and this now stands at the junction of the small and long corridors. In the accompanying letter Mr Ferguson said :

'Mr Marks departed this life on May 2, 1895, leaving all his means for the poor and needy of this community. The deceased was a Pole by birth and a Hebrew by persuasion. He was an ardent admirer of the British flag, in fact he was in the habit of saying that by comparison there was no other flag fit to live under. In proof of these sentiments he left all he had, in round numbers £20,000, to the poor and needy of the land of his adoption.'



THE ROYAL VISIT OF 1954

Her Majesty is accompanied by Mr V. C. Lawn, Chairman of the Board, and Dr T. Morton, Medical Superintendent. Behind are Mrs Lawn, Mrs Chambers and (mainly obscured) the Duke of Edinburgh.



The nursing staff with Matron Ewart and Dr T. L. Crooke. (Date unknown but between 1900 and 1908.)



Matron Thurston, Dr F. L. Scott and Sisters (1909).



CONSULTING STAFF, 1962

Sitting: Dr. Malcolm Gray, Dr. W. Mark Brown, Dr. R. H. Quentin Baxter, Dr. Caroline Stenhouse, Mr. J. Leslie Will, Mr. L. A. Bennett.
Standing: Dr. F. O. Bennett, Dr. W. G. Seannell, Dr. Melville H. Aiken, Dr. E. R. Reay, Mr. J. Keith Davidson, Mr. W. M. Cotter, Mr. D. G. Radcliffe, Mr. David Macmillan, Dr. D. McK. Dickson.
Absent: Dr. C. T. Hand Newton, Mr. F. Stanley Foster, Dr. Arthur Thomson, Dr. Malcolm Robertson.



MEDICAL STAFF, CHRISTCHURCH HOSPITAL, 1962

(This photo includes with the existing staff several recent members since transferred to Princess Margaret Hospital)

Back Row: G. W. Holland, A. H. Foate, P. W. Cotter, A. W. S. Ritchie, R. D. Suckling, J. B. Jameson, F. T. Shannon, J. W. Ardagh.
 Fourth Row: E. G. Perry, W. J. Smith, G. I. Louissou, B. B. Fazackerly, T. Hurrell, P. M. Tripp, G. C. T. Burns, W. O. S. Philipps, A. D. Muir, R. D. Scott, W. L. F. Utley, J. Bremner, R. C. S. Dick, W. I. Paterson.
 Third Row: A. F. Burry, D. R. Hay, R. F. Hough, J. M. Louissou, A. C. Sandston, D. A. Larnder, W. J. Pryor, T. P. Cannon, T. S. Weston, D. W. Beaven.
 Second Row: J. R. E. Dobson, W. L. B. Burns, A. B. Mackenzia, R. Blunden, I. D. Gebbie, M. S. Smith, J. A. K. Cuninghame, S. C. Peddie, N. F. Greenslade, H. R. Donald.
 Front Row: A. M. Hartnell, C. G. Riley, D. T. Stewart, J. F. Landreth, T. Morton, W. Bremner, G. L. Rolleston, H. E. H. Denham.
 Absent: T. R. Anderson, W. B. Barlow, D. C. T. Bush, S. M. Cameron, A. J. Campbell, P. S. Cook, K. D. Drayton, H. W. J. Fox, R. D. Gibson, A. M. Goldstein, J. D. Greatrex, C. Gresson, F. W. Gunz, E. E. Hannah, W. A. Liddell, C. J. J. Morkane, E. H. H. Taylor, H. T. Thompson, H. J. Wales.

CHAPTER ELEVEN

63/29

Enter the Health Department

THE FIRST DECADE OF THIS CENTURY IN THE HOSPITAL WAS more progressive in thought than in action. It was a peaceful period. Many of the Board members were new but had not forgotten 1895. The Board became concerned with administration and finance; the staff with technical progress in medicine. The seeds of mutual respect were planted and grew the better for being in isolated plots. It was in this period that there was felt the harmonising influence of women Board members and of nurses. The special departments began to have their humble origins. The staff was increased in 1909 to four surgeons and four physicians though the later Board reduced this to three of each.

It was not a progressive period architecturally nor could it be with the existing legislation. The main building on the hospital premises was the house surgeon's residence. The house surgeon was Dr Leslie Crooke, appointed in 1899. In 1903 he announced his intention to marry and the Board gave him a week's leave provided he could secure a satisfactory locum. His wife, not unreasonably, demanded a decent home. So in 1904 at a cost of £1535 the Board built a home which in turn was to house Drs Crooke, Scott, Fox and Nelson. It is the structure which after modifications became the offices of the Board in 1956. Its erection meant removing the porter's lodge. With the lodge went a large bluegum, a well known landmark. The Board silenced the usual protests about this by pointing out that the tree was very badly diseased—half way up where no one could see it.

The Board made a mild and ineffectual attempt to elevate

its previous conflict with the Drainage Board into a vendetta. It complained that the open drain in Lincoln Road smelled. The Drainage Board said it did not smell and sent Dr Symes to confirm this. He inspected the wrong drain opposite the Marks wards and reported favourably. The Board called on the matron and the nurses. They said it did smell. The drain was closed in.

The real troubles of the Board at this time were not so much domestic as national. It was not the doctors who first started to specialise but the patients. There was the chronic invalid, the aged and frail, the alcoholic, the difficult pregnancy for whom the hospital had no accommodation and for whom under the existing legislation none could be provided. So the Board, like most other Boards in the country, appealed repeatedly to the Government either to take responsibility for these cases or to create machinery whereby the Boards could do so. The various Boards were in frequent communication one with the other and this paved the way for the Hospital Boards' Association. The major problem was the chronic invalid. In the opinion of most Boards the solution was a large Government infirmary in each island. Fortunately for the patients there were no funds for this and the Government was criticised unfairly. It had just taken the first step in social security with the tremendous experiment of old age pensions. In 1905 it voted £2000—£500 for each centre—as a nucleus for a chronic ward fund. This was like giving a hungry man a crust and a cookery book. The Prime Minister, the Rt Hon. R. J. Seddon, met the Board in Christchurch and discussed the whole matter sympathetically but a few weeks later he died. The pressure after all was less by Hospital Boards than by Charitable Aid Boards.

Another issue was the treatment of alcoholics. The Board, once more irritated by a magistrate ordering an alcoholic to hospital, circularised other Boards and they presented a united case pleading for special accommodation and special treatment other than by nurses. The Government agreed to maintain such patients if the Boards would build padded cells for the purpose. (The Board deferred providing these till 1922 and at a later date was reproved by the Government for the delay. They are now known as the Annexe.)

The confusion over responsibility for special cases was well illustrated by the melancholy story of Mrs Priestly. She suffered from lupus of the face which was chronic, incurable and a gross cosmetic disability. Because of her disease the Charitable Aid Board referred her to the Hospital Board and because there was no treatment the Hospital Board referred her back. Both Boards agreed however that she should be the responsibility of the Government. Eventually she was quartered in a tent on the hospital grounds and later in a portion of the second ward 3. After a time she became insane. The Board tried to transfer her to Sunnyside but this was opposed on the grounds that there was no special accommodation and that she could not associate with other patients. A deadlock ensued and the Government was asked to arbitrate. It ruled that she should stay where she was and her maintenance would be paid by the Government. There, in almost solitary confinement, she stayed until her death, her shadowy form often to be seen at dusk as she crept out to gather fallen twigs for her fire. It is not surprising therefore that a little later when Sunnyside wanted a mental patient admitted to hospital for operation the Board refused. It had no special accommodation, the patient could not associate with other patients etc.

Gradually the combined pressure of many Boards forced the Government to action. Two amendments to the Act of 1885 were passed in 1909 and 1910. The principal clauses were those that combined the functions of hospitals and of charitable aid under one Board. This was a reasonable acknowledgment of the idea that the sick and the indigent had equal claims on the community and that a single control would have considerable administrative advantages. Many minor clauses were written into the legislation and some of them greatly increased the power of the Health Department. The Inspector General was careful to submit a preview of the draft to the more responsible Boards. Most of them, including North Canterbury, recorded their objection to the clause whereby the appointment of superintendents and matrons was dependent on the Department's approval. Dr Valentine took note of all the objections but the clause went through unchanged.

The Health Department was formed in 1900. It replaced

the ancient, ineffective Central Board of Health and it sprang from a rushed piece of urgent legislation in the face of the threat of bubonic plague which had appeared in Auckland. It was given wide powers and when the urgency passed the powers remained and have steadily increased.

Plague is the greatest of all slayers of mankind. Its appearance in any community is regarded as a tragedy. Yet when it did come to Christchurch (in the form of one case and a few doubtfuls) the tragedy, if any, trailed far behind the comedy.

The patient was a man named Shields and his plague was diagnosed at Lyttelton in 1902, and confirmed by Dr Mason who was an authority on the disease and who was the Chief Medical Officer of Health for New Zealand. There was an instant demand from the public that he be sent to Quail Island, the Chathams being regarded as less accessible though otherwise preferable. But the doctors, unmoved by the hearty appearance of the patient, considered the journey to Quail Island too hazardous and transferred him to ward 3 at the hospital. They also transferred all responsibility for any epidemic to the Board. As the Board's resources were confined to ward 3 which then contained twelve beds less one and plague is a pestilence which in Constantinople for instance has killed 10,000 in a day, the situation could not be regarded with equanimity. While deliberating, the Board offset any public criticism of inactivity by calling on the whole medical staff to see Shields in consultation. All complied except Dr Thacker who was concerned more with the prognosis than the diagnosis and resolutely refused to go near him. This gave the Board at least one positive line of action. It demanded Dr Thacker's resignation and appointed Dr Wm. Irving. It also decided to build a new plague hospital and in less than a week had erected a shanty town of wood and canvas at Burwood. Dr Fenwick who had seen plague in the Boer War was recalled from Wanganui and put in charge. A few other cases joined Shields to justify the whole exploit but they were very doubtful cases of plague. There were about equal numbers of staff and patients. All recovered, all had a good time in their rigid isolation and when they moved out a few Boer War veterans with

tuberculosis moved in and in such bizarre circumstances the present Burwood hospital had its origins.

So in the shadow of the bacillus pestis the Health Department was born and by 1910 had a firm grip on hospital control. Ten years later the power had increased. Any expenditure over £500 had to go to Wellington for approval. As prices rose during the war more and more projects and purchases came into the £500 class and less autonomy rested with Boards. In 1920 the Department took over from the Board the sole control of Public Health Inspectors. In 1922 the distinguished American hospital expert, Dr M. MacEarchern, visited New Zealand. He had varied criticism of many hospitals but in general praised Christchurch. But he sensed with some apprehension the growing tendency of the Department to intrude at all levels of hospital administration. He recommended that 'the chief supervisory capacity of the Department be superseded by a controlling function exercised by some central non-political Board.' The recommendation has been repeated many times since but it has always to be made to the Department itself. It is like trying to persuade a dictator that he could better serve his country by becoming a controller of customs. It is significant that in 1924 the North Canterbury Board abolished its Policy Committee. Policy had shifted to Wellington. In the following year when the annual conference of hospital Boards was held in the new Wallace ward in Auckland, the suggestion first mooted by North Canterbury was adopted and the New Zealand Hospital Boards' Association was formed. The motive was partly defiant but it soon became defensive.

But little of this was foreseen in 1910 when the powers of the Department were quietly consolidated by legislation. The old Board had confidence in future autonomy. Its first act when it was constituted in 1885 was to dismiss all its medical staff. Its last act on the eve of its dissolution was to ask the staff to carry on.

CHAPTER TWELVE

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A Period with Carpenters

THE YEAR 1910, BRIDGING THE TWO HALVES OF A CENTURY, owes its importance not to an artificial division in time but to the new control that favoured forward progress rather than conservative reluctance. Thereafter the hospital began to accelerate in its confident move into the new century and gained a momentum that was not to be arrested by the calamities of a depression sandwiched between two wars. And in its progress it jettisoned much of the sodden cargo of the past. It was easy to do this in the matter of charitable aid where the unfortunate victims, deep in a social dungeon, were not permitted to live and not allowed to die but merely to exist. The new Board, entrusted with charitable aid, began to step up both the charity and the aid. It looked at the orphans and saw them as potential citizens and not as the diseased progeny of a degenerate stock. It spoke with pride of its nursing staff. It ceased to police the doctors and gave them responsibility and had the loyalty reciprocated. Something near to a revolution had been averted in 1895 but it speeded up the evolution of new thought and new methods and by 1910 the old philosophy was back out of sight behind the bend in the road.

The Board started off by a little administrative spring cleaning. The Government stated that the ideal Board would have fifteen members. In the hospital Board room the alternative of twenty was selected and this preference was successfully defended for fifty years. Mr Miller, secretary for twenty-four years, resigned. The Board entered a special appreciative minute and probably caused a tremor through the cemetery by granting him a year's leave on full pay. Mr T. C. Norris who

as the famous secretary of the Charitable Aid Board had almost as long a service, became the new secretary.

The Board then appointed Mr F. Horrell as Chairman. Five sub-committees were formed with seven members on each.

- 1 Hospital Committee.
- 2 Public Health Committee (Sanatorium, Bottle Lake, Akaroa, Lyttelton Casualty Ward).
- 3 Charitable Aid Committee (Charitable Aid, Armagh Street Depot, Samaritan Home).
- 4 Institutions Committee (Tuarangi, Jubilee, Female Refuge, Orphanage).
- 5 Finance Committee (Finance, estates and bylaws).

Internal matters thus settled, the Board considered its urgencies and found that further building was at the top of the list. It then embarked on an extraordinary campaign of progressive construction. It started by entering a minute that wards 4, 5 and 6 should be pulled down being 'so old and out of date as to be practically useless'. Fortunately erection had to precede demolition and now, fifty years later, various pressure groups in the hospital are still competing for the right to occupy these wards.

But these wards no longer stand alone. In the four years between 1910 and the first war £100,000 was spent on capital outlay. Between 1910 and 1920 wards 1, 2, 3, 9, 10, 12, 13, 14 and 15 as well as the administration block, the main corridor and the subway were built. (The same Boards in the same period were responsible for the Sanatorium, Coronation Hospital, a new block at the Female Refuge, the morgue and hospitals at Kaikoura, Oxford and Waikari). The bed state in all the Board's institutions in 1910 was 184; in 1918 it was 427. There was courage and vision behind all this. Nothing was built that failed in its intention. The contributory bodies of course had to pay. They sent their cheques but withheld their praise. Nevertheless the Boards, even if not popular, were respected.

One major project, the children's ward, was inherited from a past Board. Such a ward had been approved by the Board in 1905, advocated by the Inspector General in 1908 and

almost demanded by the staff in 1909. Lacking only money the Board decided to appeal again to the public. Most of the work of raising funds was done by an energetic ladies' committee. Within a few months of launching the campaign the ladies handed £3770 to the Board. The fund continued to swell and a year later had grown to £4586. This carried a twenty-five shilling subsidy. The generosity of the donors is still commemorated on the brass tablets outside ward 9.

The Board then decided that as a women's surgical ward was advisable and would soon become necessary, it would be wise to combine both wards in the one building. This is then the origin of ward 10. There was only one logical site—further west beyond the Marks wards. The entrance to the ward was placed at the south end as opposed to the northern entrance to the old wards. This was in anticipation of the next stage of reorganisation. The plans were drawn by Messrs Collins and Harman but they worked in conjunction with a special building committee which included representatives of the ladies. The successful contractor was Mr W. W. Smith (£14,292).

The first trouble was with the foundations. As with the Marks wards and the later Nurses' Home, these had to be carried much deeper than was first anticipated. The foundations cost the Board an extra £2500 which was authorised by the architects without the Board being first informed. The Board was not so reticent in its opinion of the architects. Once the construction was commenced the old building committee ceased to function but later, at the request of Mrs Crooke, it was reconstituted (Dr and Mrs Crooke, Miss Thurston and Dr Acland). From Mrs Crooke came the suggestion of the tiles in ward 9 embodying some of the exploits of the classical folk of nursery rhymes. The Board immediately agreed and added another £100 to the cost. Later generations have been critical of this type of mural decoration which is of course the inevitable fate of all art. But the tiled designs in ward 9 are not for the sophisticated and many a child has tempered its chagrin at the defection of its parents by the loyal presence in the ward of its contemporaries from that real land where the fairies dwell. The building committee also had £547 reserved for

furniture and equipment which included a special fund of £67 for toys.

During the construction of the wards the contractor, Mr Smith, died and this added further to the delay. The new wards were opened on June 15, 1911, by the Minister in Charge of Hospitals, the Hon. Mr Geo. Fowlds. Almost immediately after this ward 9 began to fill with cases of diphtheria.

When in 1910 the United Charitable Aid Board ceased to exist by being absorbed in the new Board, its premises in the Armagh Street Depot were left vacant. The Hospital and Charitable Aid Board decided to move there. A short experience, however, proved that these premises were quite unsuitable. So too was the old Board room at the hospital (now the Splint Department). Equally difficult to accommodate was the growing clerical staff. The administrative facilities had improved very little in the last fifty years. It was accordingly decided to deal courageously with this problem and many associated ones by building a comprehensive Administration Block.

Plans were therefore prepared. They were very similar to the building that now exists. But the Inspector General, Dr Valentine, regarded them as too elaborate and rejected them. A deputation from the Board, after co-opting Dr Acland, went to Wellington to argue the matter and kept on arguing until Dr Valentine came to Christchurch. He said the plans were excellent—too excellent in fact. One storey would be sufficient, allowing more to be spent on isolation wards and on renovating ward 6. The Board thereupon compromised. A small portion of the block which contained (until 1956) the general office and the secretary's office was built in 1912. Its entrance was from the courtyard by a sloping ramp which still persists. The major plan was proceeded with in 1914. The out-patients' department, porters' lodge, staff room and dispensary on the ground floor with pathology department, dental department (since removed), Board Room and house surgeon's quarters on the next floor were built by Mr J. Smith at a cost of £14987. As the house surgeons moved into their new quarters the maids came down the stairs from the cramped attics of the old wards and took over the abandoned rooms in the old

administration block (later known as the A.D.M.S.). Underneath portions of the new administration block were two basements. One, approached by what must be one of the most hazardous stairways in the world led from the main office down to a dungeon where forty years later were to be found old hospital records, forgotten receipt books, out-patient cards of a past generation buried in a soft grey dust. The other, accessible by the stairway near the present staff room, was the bulk store until this was transferred to the new site across the road. It was then equipped with shelving and is now the main storage depot for the Records Department.

At the same time the present main corridor was built. An addition to the old corridor had taken it beyond ward 6 to ward 7 but, owing to the ophthalmic ward it could not go further. When ward 9 was built the old corridor was made to branch at right angles again to give an entrance to ward 9. This last portion was the beginning of the new corridor which four years later was extended the whole length of the hospital and which has continued to grow at both ends as the hospital has spread.

This new corridor, now a sixth of a mile long, where the traffic never stops night or day, is the main arterial trunk of the hospital. It is far more than a covered way. The external construction is brick, solid and in places that cannot be seen, ornate. The roof is flat and affords access between second storey wards, while underneath is the subway. The corridor is the most important architectural feature of the hospital. It provides a suggestion of spaciousness, economises distances and gives the pavilion-like character to the hospital which was sought after by the earlier designers.

The subway is an underground passage on which that part of the corridor which runs from ward 9 to ward 4 is built. At various places a sloping ramp leads to ground level. It is the width of the corridor and high enough to take careful pedestrians. In the roof and walls run the steam pipes, water pipes and electric cables, thus providing easy access for maintenance. Until recently it was also used as a convenient route for garbage and soiled linen.

The corridor and the Administration Block completely

changed the character of the hospital. The subway was built first by independent tender (Messrs Nightingale £3047). The initial extensive excavations at the rear of the old wards made desolation even more desolate. Part of ward 3 had to come down and the sewage pipes from the Marks wards had to be relaid. Then, while the engineering staff was busy installing the mains for power, heat and water in the subway the corridor above was built, the wards were broached, the short corridor from the porters' lodge was constructed and the rest of the block completed. As a result the whole hospital was turned round. The new southern entrance became the front door. Dust and dinginess began to accumulate in the old corridor though even at present there is a dignity in its kauri beams which its painted rival cannot challenge.

The Board then turned its attention to the problem of infectious diseases. In 1912 Dr Valentine had submitted a set of model rules for nursing such cases and they demanded rigid isolation and generous floor space. All that was available at the hospital was the Isolation Ward, ward 3, already partly demolished. The great safety valve for epidemics, of course, was Burwood but Burwood had limited facilities for special cases. The Board therefore decided to build a two-storey block (wards 12 and 13) with a number of two, three and four bed rooms. The site was obvious—further west beyond ward 9. It was estimated to cost £5000 but the final contract was let to Messrs Greig and Son for £6400. These wards were only about half the size of the present wards of the same name. The construction proceeded without special incident and the wards were opened early in 1914. Almost immediately the top floor began to fill with poliomyelitis cases. In a total of thirty-five victims there were three deaths. In a hospital which has always been short of single rooms these wards were invaluable. Before wards 12 and 13 were completed the Board decided that they should be connected to the main corridor by a covered way. This was built for £290. At the same time the remnants of ward 3 were dismantled. This, the second ward 3 in the hospital, had an inglorious career. It had been too big to be opened for the few cases and too small to house the many and for most of its

existence it had been shut. Its greatest period of usefulness was when it had been used as an auxiliary nurses' home.

Throughout all this, however, there was the constant demand for wards for chronic patients. The expectation of life was rising, the population was ageing and long invalidity often preceded death. From the honorary staff and the Superintendent petitions went frequently to the Board which in turn consulted other Boards and were associated with them in requests to the Government to solve the problem on a national basis. The Government, however, stoutly maintained that each Board had its own duty in the matter. The credit for attempting to break this deadlock in Canterbury goes to the Hospital Lady Visitors' Association (H.L.V.A.).

At a meeting in 1912 the H.L.V.A. courageously decided that it would make an attempt to raise money for a chronic ward. It began an arduous campaign, characterised by many people making big efforts for small sums. All the committee members (and others) took subscription books, a garden party was held, collecting cards were sent out to the schools and bridge parties were organised. Slowly the fund grew. Then came the promise of £1000 by Mrs Townend, which was still only a promise when Mrs Townend died shortly after. The principal beneficiary repudiated the promise and declined to give anything although the trustees later offered £4000 in mortgages which was accepted. The campaign was marked by frustrations and disappointments. The appeal was acknowledged as a worthy one but did not fire the public imagination. The war broke out and patriotic appeals swamped the minor ones. By this time the H.L.V.A. had collected £2066 exclusive of subsidy. It was far short of what was required but it was solid enough to allow a grateful Board to shelve temporarily the matter of cost while it decided the matter of site.

There was little available ground left. A small ward could perhaps have been erected in front of the Marks Ward and the architects were even instructed to peg out a site. The Hospital Committee gloomily studied the result and the pegs were taken up again. Between the hospital and the river was land enough but special legislation would be required to make it available.

The search for the site kept drifting back to the hospital entrance and the shabby senility of ward 1. How long was it to persist? It was over fifty years old and too inconvenient to be of much use. If it was to be demolished why not now? Its younger neighbour, ward 4, had been officially condemned and £8000 placed on the estimates for its successor. As the idea grew in favour so did ward 1 increase in disfavour until finally the Board passed a resolution approving of the chronic wards being erected on the site of ward 1 'as no other suitable site is available'. An amendment to substitute 'if' for 'as' was lost.

The original intention of the Board and the H.L.V.A. was to build two modest wards, one for each sex. It was hard to get beyond this point. Although the Board had for years been advocating the creation of national Government-sponsored hospitals, it had no clear idea of the form, shape and size. The number of chronic patients was unknown. What was known was that the cost of building was steadily rising during the war and, relative to their purchasing power, the donated funds consistently shrank. New wards of course would need new furnishings and there was no special provision for these. There seemed no escape from the conclusion that war and wards would not mix.

Then the situation was suddenly changed by a magnificent and unexpected gift. It came from Ashburton, quietly and discreetly, and in those days when the only news was war news the true drama of early colonisation behind the gift was hardly known and less noticed.

The story originates in Scotland and shortly after transfers to New Zealand where in the early days of the province some rich land between Ashburton and the sea was purchased (some of it at £2 an acre) and by means of hard work was transformed into a highly productive farm. In the farmhouse lived three generations. Old Mrs Chalmers, a widow, kept house for her two bachelor sons John and Peter and her young granddaughter Jean, who was an orphan, her father having died just before her birth and her mother (Mrs Chalmers' daughter) just after. When Mrs Chalmers died, Jean—who had by this time taken the family name—continued to look after her two uncles. John died in 1894 and left his niece about £4000.

Peter died in 1901 and Jean inherited £85,000. In April 1915 Miss Chalmers informed the Board that she was willing to donate £8000 for wards for chronic cases. This was to be a memorial to her two uncles. The Board was to build and administer the wards at its discretion, the only stipulations being that the wards were for chronic cases and that special consideration should be given to poor patients from Ashburton.

The gift was most gladly accepted and successful application was made for the 24/- subsidy. This lifted the whole project on to a plane of enterprise that excluded any further thought of two humble wards. The Board gave instructions to the architects, Messrs Collins and Harman, to prepare plans for a three-ward block in brick. The contract was undertaken by Messrs Greig and Son (£12,800), Miss Chalmers laid the foundation stone on February 23, 1916, and seventeen months later the wards were officially opened.

This Chalmers Block is the most valuable building on the hospital site. Without it the hospital services of the city would have broken down many years ago. Each of the three wards is very large and about half of each ward is surrounded by a 10 foot wide verandah. Side rooms and service space were generous in the original plans but about 1952 were considerably extended when some major reconstructions were effected including the installation of a new lift. Some of the machinery of this lift is housed in the tower which surmounts the top ward.

These were to be special wards in that they were for chronic and incurable cases. Their splendour was such that envious eyes were cast upon them by those who could willingly have used them for other purposes. For the time, however, this was not to be. The Board appointed a special committee to draw up regulations for admissions in terms of Miss Chalmers' wishes. The subsequent wording was lengthy but, briefly, it stressed the preference for the chronic case especially if young and entrusted the final selection to the Medical Superintendent and the committee.

On various occasions in the subsequent years ill-informed critics have asserted that the Board has 'broken its contract' by admitting other than chronic cases to the Chalmers Block.

There was no contract to break. The restriction of these wards to incurable cases has as its sole authority the wish of Miss Chalmers and it would be idle to pretend that this was to persist beyond all the modifications of time and circumstances. When the wards were built the various special departments were in their infancy and no one could foresee that the hospital was to become a base hospital for the province and that advances in hospital practice throughout the world would necessitate distant subsidiary hospitals for chronic cases such as have been provided at Burwood, Jubilee, Tuarangi and Coronation. Criticism of the Board would have been justified if the Chalmers Ward had been taken for general purposes and no alternative provided. Miss Chalmers provided wards for the incurables and through her generosity they have had wards ever since. The Board's action has the approval of the trustees of Miss Chalmers' estate. This was granted at a meeting in 1937 when the trustees and the Board conferred and the Board stated its intention of providing alternative accommodation at the new Cashmere Hospital but the complexities of hospital administration due to the war made it necessary to reserve the Cashmere site for general hospital purposes and substitute the wards at Burwood for incurable cases.

It is ironical that if there was any breach of faith it was by the H.L.V.A. Their funds had been collected for chronic wards but Miss Chalmers' gift made this fund redundant. It was invested, the interest applied to various hospital amenities and the capital eventually used for the building of ward 11.

The generosity of Miss Chalmers has created an enduring monument not only to her uncles but to herself. It is represented in buildings and in public esteem and is annually revived by the direction of her will. She left two sums each of £10,000, one to the North Canterbury and the other to the Ashburton Hospital Boards. These were to be invested and the interest from each was to be used for the maintenance of the Chalmers Wards in Christchurch and the Women's Ward in Ashburton Hospital respectively. If in the latter case there accrued more money than was necessary for the purpose, the surplus was to be equally divided between the Chalmers Endowment Fund and the Ashburton Hospital Board. (The

whole estate, augmented by judicious land purchases, steady investments and increasing value of the assets, realised at Miss Chalmers' death approximately £220,000).

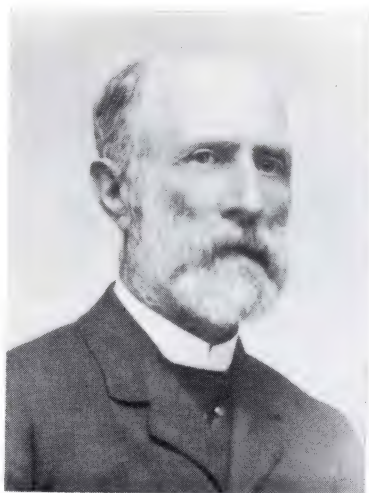
She was over eighty when she died in 1936 and she left no relatives but she had not forgotten the comment of her uncle Peter that if he had not been leaving his money to her he would have left it to hospitals primarily for the chronics and incurables. By her direction the residue of her estate was formed into a perpetual trust and the annual interest was to be divided equally between Christchurch and Ashburton Hospitals. At present each hospital is receiving approximately £1800 a year from this source.

This humble family of Scottish immigrants has now passed from the face of the earth. But in the land of their adoption their memory will long survive.

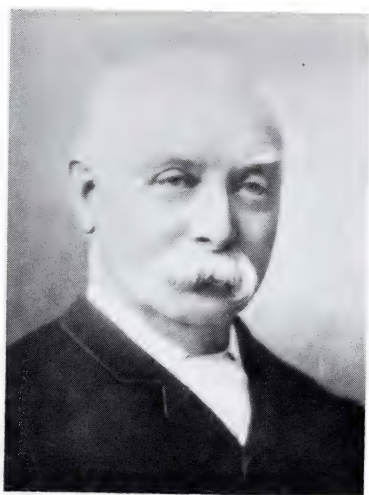


THE NORTH CANTERBURY HOSPITAL BOARD, 1962

Seated (from left) : Miss B. Webb, Mr A. J. Danks (Deputy Chairman), Mrs J. E. Mackay, Dr L. C. L. Averill (Chairman), Mr L. A. Bennett, Mr D. Macmillan, Mr E. P. Shier.
Standing (from left) : Mr J. G. Laursen (Secretary), Mr T. F. Carter, Mr Turner Smith, Mr R. J. Roberts, Dr J. Morton (Medical Superintendent-in-Chief), Mr J. B. Hay, Mr V. J. Corbett, Dr I. C. Macintyre, Mr D. Horne (Assistant Secretary).
Absent : Mr H. O. Hills.



Mr T. C. Norris



Mr W. Miller



Sir Hugh Acland



Dr T. A. MacGibbon



Dr C. T. Hand Newton



Mr W S. Wharton



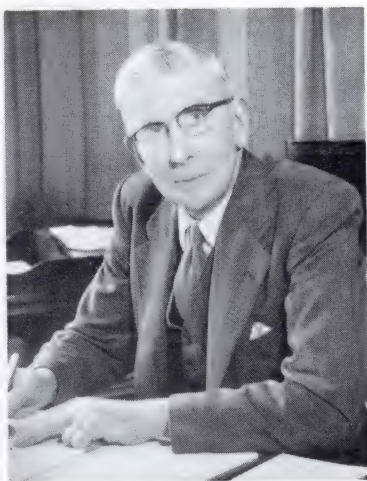
Dr Neil Guthrie



Dr P. Clennell Fenwick



Dr A. D. Nelson



Mr A. Prentice



Dr A. B. Pearson



Mr P. Stanley Foster

CHAPTER THIRTEEN



The Reign of Dr Fox

AS THE HOSPITAL RAPIDLY CHANGED IN SIZE AND SHAPE SO DID equivalent changes occur in the staff.

Mr Norris, secretary to the new Board, broke down in health in 1912 and on medical advice was forced to resign. Mr Wharton was appointed. Mr Norris had spent nearly twenty-seven years in the administration of charitable aid. The Board recorded its high appreciation of his work and voted him six months' leave on full pay. This, in the opinion of many (including Mr Norris) was not very generous. It certainly tended to overlook how the Board's funds had been conserved by Mr Norris's innumerable small economies. Attempts on the Board to increase his leave first to twelve months and then nine months were defeated.

Dr Crooke resigned as house surgeon in July 1910 and commenced private practice. There are still some who remember appreciatively his kindly disposition, his gentlemanly manner and his musical ability. He was followed for a period of nine months by Dr P. S. Foster, who has throughout his long surgical career been intimately associated with the hospital as house surgeon, honorary surgeon, visiting surgeon, Director of Surgical Services, consulting surgeon, and for many years a Board member.

In 1911 the Board, on the recommendation of the Inspector General, appointed three junior house surgeons in addition to the resident house surgeon. The experiment was not altogether successful. The decision was then made to appoint a medical superintendent who would have special ability in administration. Pending the appointment Dr Pentreath acted for three

months as senior house surgeon with Dr Widdowson (later to be honorary surgeon, and then superintendent of Wanganui Hospital) and Dr Mary Glowery as assistants.

The first appointment of a medical superintendent caused considerable interest. There were twenty-two applicants from New Zealand, Australia and South Africa. The Board made a preliminary survey and reduced the number to half, being to some extent influenced by the fact that it considered the best age was between thirty and fifty. One Dunedin applicant with high qualifications (Dr F. L. Scott) failed on the casting vote of the chairman to get on this approved list mainly because he was only twenty-seven. The eleven were shortlisted again to three (Drs Birks, Harke and Mill) and the names were sent to Dr Valentine who approved them all. The Board then held a special meeting to make a final selection. Its first decision was to add Dr Scott's name to the list. Its second decision was to appoint Dr Scott as medical superintendent.

Dr Scott applied himself with the enthusiasm expected of a young man in a growing institution. His reports to the Board usually had practical suggestions for assisting the administration and of these the Board invariably approved. He had loyal support. Dr Fox was chairman of the honorary staff. Miss Thurston had been Matron since 1908.

For three years the clinical work progressed smoothly and then came the war. The main effect of the war was on the staff. The hospital itself continued to expand and the bed state rapidly increased. As in all other sections of the community the national danger acted as a stimulus and the work potential of the staff was increased. Before the end of 1914 Drs Fenwick, Acland and Guthrie were in the army. At the first meeting of the Board after the declaration of war a typical cross section of the staff tendered their resignations for military reasons—Dr Trotter (house surgeon), Dr Hercus (house surgeon and later to be Sir Charles Hercus, Dean of the medical school), Sister McNie, Mr Saunders (dentist) and Mr A. Pidgeon (porter). Others who went early were Dr Hand Newton and Mr Knight, master of Tuarangi. Later, Dr Duncan departed leaving Dr Ellis in charge of the infectious diseases. Then Dr Scott went overseas and Dr Fox agreed to act as a temporary super-

intendent—a decision which gave the Board much satisfaction. Miss Thurston became matron of Walton on Thames and was replaced at Christchurch by Miss Rose Muir.

The full roll of volunteers is far too lengthy to detail. The Government announced that vacancies created by persons going on active service were temporary. The Board agreed and gave each departing volunteer a month's salary. Later, however, it frequently appealed against the enrolment of some key person. In both this war and the next no finer service was rendered by medical men than that given by some of those who stayed at home. Though worked often to the stage of exhaustion they yet filled all vacancies at the hospital and effectively dealt with the increased sickness due to recurrent epidemics of scarlet fever and diphtheria throughout the war.

The staffing difficulties were not confined to the honorary staff. Previous to the war house surgeons had been appointed for one year only. During the war they were barely available at all and, particularly in the vacation, medical students were substituted. Even this was a thin source. First and second year students, if of age, were liable to conscription. Fourth and fifth were compulsorily retained and even had their courses shortened and examinations advanced so as to lead to a slightly earlier qualification, after which they usually went into the army. In 1917 the Board advertised for two qualified house surgeons at £450 a year each but the money could not buy what was not available. For most of 1918 the vacancies at the hospital were filled by final year students.

Dr Scott was released from military duties in 1916 and resumed as medical superintendent. A few months later he resigned and commenced private practice. He quickly established a reputation as a surgeon and as a family doctor and more recently as medical officer to the police force. He died in 1961. The Board called for new applications. Five were received. There was no application from Dr Fox who by now was also in the army doing medical work in Auckland. Private enquiries as to whether he was interested in the appointment revealed that he was, but being in the army he considered himself not available. The Board, however, had powers in this direction. Within a few weeks Dr Fox was released from

military responsibility and he resumed his old post of medical superintendent, a position he was to occupy for another twenty years.

Less smooth was the homecoming of Miss Thurston in 1919 from her position as matron in chief of Walton on Thames hospital. The Board had been proud of her appointment but after two years had wanted her to return. When she refused the Board considered the contract cancelled. She reapplied but on the casting vote of the chairman the application failed and Miss Muir was confirmed as matron. Previous to Miss Thurston's departure on active service the Board had approved eight months' leave of absence on full pay for a visit to the United Kingdom. This promise was now confirmed and she was given an additional six months' pay in lieu of reinstatement. The R.S.A. appealed on her behalf but was not successful. The matter, however, kept recurring and in 1927 she was granted a pension of £50 a year. For this Government approval had to be obtained but a precedent had already been set in 1924 by providing a pension for Miss Ewart.

Not all who went to the war came back. Nurse Nora Hildgard, Nurse Lorna Rattray, Nurse Margaret Rogers, were all victims of the torpedoing of the *Marquette* in the Mediterranean. Dr J. K. Venables, a previous house surgeon, was killed in action. The Board at a later date decided to name three hospital wards after the three nurses, but went no further than making the decision. Brass plates in the chapel record the names.

New Zealand had a tragic participation in the great influenza pandemic of 1918-1919. The first wave, mild and disarming, moved through the country from July to October and like the so-called Asian influenza of 1957 it had a high morbidity and a low mortality. In August 1918 there were 206 deaths in New Zealand from catarrhal diseases, 49 of them in Canterbury. The high infectivity was illustrated at Christ's College where from October 15th to October 18th 127 boys were attacked. Despite the lesson from overseas that a second wave if it came would be virulent and deadly the country was not particularly perturbed. It was in fact in gay mood as the armistice was near.

The second wave started in Auckland at the end of October and then erupted in the South Island almost with the violence of an explosion. The race carnival opened on November 4. To it came visitors from Auckland and Wellington bringing the infection and transferring it to those who came from Otago and Southland. On November 6 seven cases were admitted to Christchurch Hospital and the first cases were appearing in Dunedin. On the 8th, great crowds congregated in the streets at the false news of the armistice. On the 9th (a Saturday) and 10th hundreds of people in the province had taken to bed and there were ugly stories of ugly deaths. When on the 12th there came news of the armistice of the previous day there was little jubilation in a stricken city. True, the papers gave larger headlines to the peace than to the pestilence but this was purely a journalistic preference, for the pandemic in four and a half months slew more people in the world than as many years of war had done. All through, the papers preserved an optimistic note and though in some quarters there was panic it was no fault of the press. The press in fact was almost the sole means of disseminating information and instructions to the public and its role was invaluable.

In Christchurch as elsewhere there was a magnificent response to the emergency. A citizens' committee was formed. The Medical Officer of Health, Dr Chesson, issued instructions and the committee amplified them and implemented them. All churches, schools, amusement places were closed and congregations of people of any sort were stopped. The city was divided into blocks and doctors for the first time found themselves restricted to zones. The District Nursing Association with Nurse Maude in charge set up a central bureau in the Square but there were eleven subsidiary bureaus. They gave nursing help, food, medicines and instructions and arranged the duties of the many voluntary workers. The Red Cross Society organised help in all the hospitals. The Automobile Association was also allotted blocks and carried food and necessities to stricken families and arranged transport. St John's Ambulance staff worked tirelessly. In fact there was no organisation in the city that did not give its fullest help. A soup kitchen was established in the M.E.D. as was also a spray

chamber where citizens were invited to inhale a zinc sulphate spray as a prophylactic (a method now known to be useless). Tramways and railways were curtailed, matriculation examinations were postponed, the sale of alcohol was restricted except for medicinal purposes. These prohibitive regulations were perhaps necessary but of vastly greater importance was the spontaneous way in which thousands of people voluntarily gave of their services in any sphere to which they were directed.

The focal point for all medical services was naturally the Christchurch Hospital. Fortunately Dr Fox sensed the special need at an early date and was aware that the hospital would have to prepare with ruthlessness and urgency. On November 9 he went to Burwood with the matron (Miss Muir) and the chairman of the Hospital Committee (Mr Sorensen) to consider its potentialities. He realised that although beds would be at a premium the real difficulty was likely to be shortage of medical and nursing staff. A high morbidity was inevitable among those who had to look after the patients. He therefore decided to try and congregate all patients in the hospital itself.

This meant the urgent clearing of beds. All the diphtherias and some chronic medical cases were hustled off down to Burwood. Other medical cases, if it were at all possible, were sent home. Only 120 patients thus remained. About 250 beds were available for influenza. They rapidly filled. The maximum incidence was on November 20 when 54 fresh cases were admitted. Thereafter there was a rapid decline and by the 27th the three weeks of horror had passed.

The hospital was quite inadequate. As a policy measure it admitted only the grave cases and by the middle of the month had 246 such patients. An auxiliary hospital was formed at the Royal Hotel, Oxford Terrace with Dr MacGibbon in charge until he too fell ill. A convalescent hospital was hastily equipped at the Addington Trotting grounds. Emergency country hospitals were established at the following places, the bed state being given in brackets—Amberley (22), Cheviot (14), Kaiapoi (35), Lyttelton (31), Lyttelton Convalescent Home (30), Rangiora (24), Oxford (20), Waikari (30).

As Dr Fox anticipated the staffing became serious, then critical and finally passed to the heroic stage. The honorary

staff overwhelmed by the problems of the public at large could not help much. Dr Fox worked literally day and night. His two senior house surgeons, Dr A. V. Short and Dr W. W. Will both took ill at an early stage. Dr Short died and Dr Will barely survived. Of the ordinary medical staff of the hospital only the late Dr F. Glasgow of New Brighton and Mr L. A. Bennett, then a final year student, worked right through without being affected. Immediately previous to the epidemic the Orthopaedic unit had arrived and Colonel Wylie and two of his medical officers, Dr Gower and Dr Ussher, were of the greatest value. Dr Fox later paid a special tribute to Colonel Wylie and his team for their administrative ability in dealing with the old military contingency of admitting a large number of urgent casualties. When at the height of the trouble Dr Fox collapsed not from influenza but from the complete exhaustion of overwork, Colonel Wylie automatically took over as self-appointed medical superintendent.

The medical problem, however, was hardly a problem at all when compared with the difficulties of the nurses. The total available nurses at the beginning of the epidemic were 137. During the critical period 70 were sick. Of the others, 17 were on duty outside the hospital and 5 on leave. This left 45 nurses to look after about 350 patients, most of whom could well have done with an individual special nurse. The matron herself was seriously ill. Staff nurse Grace Beswick and Nurse Hilda Hooker died. The remaining nurses in effect became equivalent to ward sisters directing the voluntary helpers. These last gave splendid service. They came from the Red Cross, the St John Ambulance, Sisters of Mercy, ministers of religion and finally from the ranks of the public itself. Without them the hospital would have broken down disastrously. The patients did not get any perfection of nursing or medical treatment but the victims of a national disaster never do. Despite the deaths there were some miraculous recoveries and much of the credit for this must go to the treatment, inadequate as it was.

To a large extent the internal administration was done by the porters. There was in fact no one else left to do it. They, more than any other unit of the staff, knew the hospital and all its remote resources. The admitting, discharging, control of

traffic and prevention of congestion was effected by them and on their own initiative. So with other groups. Domestic workers were doing cooking, nurses were replacing doctors, housewives were replacing nurses. Dr Pearson and Dr McIntyre were doing general practice in the city. Mr Wharton, secretary of the Board, automatically became the public relations officer. No post mortems were held that month. No pathology work was attempted other than sputum analyses. Committees of the Board did not meet. The theatres opened only for rare emergencies. The Dental Department closed.

The patients who died or nearly died suffered from pneumonia—usually staphylococcal. There was profound toxæmia and profound prostration. A peripheral circulatory failure with cyanosis frequently preceded death. Treatment was mainly nursing. There were no antibiotics. Analgesics such as aspirin, various forms of expectorant mixtures and fever empiricisms such as liquor ammon acetatis and spirits aether nitrosi were used. Hyoscine was popular with some doctors, atropine with others. One special expectorant mixture was officially approved and was on sale at a depot in the Square for patients who were unable to get medical help and in a few days the supply, not only of the dispensed mixture but of the ingredients, was exhausted. Large quantities of alcohol were used. The butchers before long were unable to supply the demand for gravy beef. Even at the present day with specific antibiotics staphylococcal pneumonia is a dread disease. It is therefore remarkable that during the epidemic more than half the cases recovered.

An additional problem was the disposal of the dead. The Health Department insisted on early burial but this was often impossible. There was no cremation, though the B.M.A. had advocated it in 1898 and its later approval by the public dated from the time of the epidemic. Special relays of grave-diggers worked in the cemeteries. In one cemetery a marquee was erected to house the coffins and in another they were placed in the shade of a tree. The funeral procession was from the cemetery gate to the grave and was to be attended only by the immediate relatives. The supply of coffins ran out and boxes roughly cut to a coffin shape with the crevices sealed with pitch were substituted. A number of the victims were returned

soldiers and at the beginning there were frequent requests for a full military funeral. The requests were peremptorily refused.

In the ten day period covering the height of the epidemic there were 477 influenza patients in hospital and of these 166 died. In all the epidemic caused approximately 6500 deaths in New Zealand.

By the end of November the hospital was struggling back to a normal routine. Wards were being cleaned out and sterilised. Departments were resuming work. Subcommittees of the Board were meeting again. All the nurses in turn got a special week's leave. Staff reorganisations were undertaken. The Board's administrative officers began to deal with the claims of those who had been requisitioned for goods or services and some indomitable spirits began to prepare for a chastened Christmas.

In the post-war period the energies of the Board continued but were now on a broader front. The country hospitals, which Mr Horrell (chairman of the Board) had advocated for many years, began to be erected. Charitable Aid institutions expanded. Improvements continued at Bottle Lake and the Sanatorium. The hospital, now firmly under the control of Dr Fox, began to produce the special departments like new plants in an old garden. Mr F. Horrell retired as chairman in 1920 and was succeeded by Mr Otley. Mr Horrell was one of the great men in the hospital history. His period as a Board member (1903-1932) bridged the old and the new concepts of hospital practice and he was one of the builders of the bridge. As chairman of the Board in 1910 he was on all the committees. By 1918 he had attended 760 meetings, having missed 11 only when he had been engaged on public business elsewhere.

In 1910 the hospital ordered its own crested crockery. In 1919 the postal and telephone bureau was established, a billiards table (£85) was bought for the house surgeons (later given to the sergeants' mess at Burnham), a cool store plant was installed (£910), the porters' wages were increased to tempt men to apply and a sixth house surgeon was approved.

In 1920 the first gynaecologist (Dr Jellett) was appointed and the new positions of honorary assistant physicians and

surgeons were created. The next year Mr Norris died after a long illness. His wife had predeceased him by three years and his only son had been killed at Gallipoli. The Board has never had a more loyal servant than Mr Norris.

For those who like to loiter in the byways of history, motives can be seen to shape themselves in the shadow of their deeds. From 1910 onwards hospital policy was no longer fabricated by the pure economist. There was a levelling of class distinctions and the hospital patient, once only a millstone round the neck of the taxpayer, began to be a person with rights. The old Boards discussed abuse of privileges. The new Boards discussed creation of facilities. There was a growing respect for the increasing ability of doctors, nurses and technicians. It was in this period that all the special departments had their origins. One factor that contributed to happier relations was the patient himself. He was now better educated, more knowledgeable, more co-operative and less prejudiced against authority. Another harmonising factor was the presence of women on the Board. From 1910 to 1917 six women at times were Board members. This did not mean that the stern stuff of Board business was sicklied over with chivalry. The women neither desired this nor needed it. There were vigorous personalities on such Boards and some had positive socialist leanings. Issues were often keenly fought and thinly won. Yet there was a commendable absence of acrimony. Said the chairman, Mr Horrell in 1917: 'I also wish to thank the members of the Board for their assistance and their unfailing courtesy to the Chair.'

One of the recommendations put forward by Dr MacEarchern on his visit in 1922 was that there should be private wards in public hospitals. There was nothing new about this. The B.M.A. had advocated it for a long time and the public approved. A certain class of patient had a strong preference for a private hospital and his own doctor. At the same time his illness might require the special facilities, apparatus or procedures which only the public hospital could supply—or, as Dr Fox expressed it, the hospital would do the kitchen work for the parlour of private practice. The Board, appreciating that private beds would probably be self-supporting, declared

its approval of the policy, considered it could best be implemented by building a new hospital, temporarily selected a site and began to consider ways and means. Then in 1922 the whole scheme collapsed. Canon Wilford announced the intention of an interested group of Anglicans to build the private hospital of St George's. It was apparent that he and the Board would be competing for the same class of patient. He offered to meet the Board and discuss the matter, but made it clear that his plans were already advanced and the hospital was certain. The Board felt that a discussion on a *fait accompli* was pointless and refused. Some individual members of the Board expressed their high appreciation of Canon Wilford as a person but the Board collectively regarded him as an intruder in a corner of a foreign field. But in a foreign field he stayed and under the foundations of St George's Hospital buried the immature infant of the public hospital's private hospital. It was hard to understand the Board's objection to St George's Hospital because the latter was only following the precedent set in 1914 by the opening of Lewisham (later Calvary) Hospital. Though sponsored by the Roman Catholic Church it freely admitted patients of all denominations and from the outset has been a private hospital of the highest efficiency.

The year 1926 saw more building. Ward 11 was erected above ward 10. It was a gynaecological ward and at the time was an attempt to limit and to treat the high incidence of puerperal sepsis. The cost was approximately £4500, of which over £2000 had been collected for chronic wards ten years previously by the H.L.V.A. The furnishings of the ward were no charge on the Board. In 1918 Mr Arthur Sims (later Sir Arthur) had begun his long career of medical benevolence by giving to the Board a sum of money which, with subsidy and interest, had by 1926 amounted to £2685. The money was in memory of his late mother and was to be applied to improved amenities for patients. The new ward was equipped from this fund. The ward remained a gynaecological ward until 1961 when it became the urological unit.

Another building project of this year was the second storey on the administration block. Various pressures made this essential. The main one was the formation of the nurses' school, an

experiment which was later copied throughout New Zealand. Also, on the floor below, the pathology and dental departments were dwelling unhappily in too close proximity. When the building was completed the dental department went upstairs and so did the nurses. The pathologists took over the vacated quarters and for a time at least were content.

The halt to capital expenditure during the depression was offset to some extent by administrative progress. Mr Otley, the new chairman of the Board in 1920, was followed the following year by Mr H. B. Sorensen who died two years later. Mr Sorensen was a Dane who, generous of time and ability, had associated himself for many years with almost every worthwhile public enterprise. Mr Otley resumed the chairmanship and retained it till 1938. He was a man of dignity with a tendency to conservatism and during the depression he was a firm and just leader. In addition to his hospital service he had to his credit two years on the Linwood Borough council, fourteen years on the Christchurch City council and thirty-six years on the Drainage Board. Mr L. B. Evans became the next chairman of the Board. The secretary, Mr Wharton, retired in 1937. He had joined the staff of the Hospital in 1886 two years after he had arrived from London. He had been a very trusted member of the staff and his retirement though inevitable was regretted. He died a few months after retirement. The Board appointed Mr Gudgeon, the Board's accountant, as temporary secretary with the intention of reviewing the situation in six months. This method was not approved by the Health Department which insisted that the position be advertised. From the thirty-three applicants Mr A. Prentice, the secretary of the Ashburton Board, was appointed.

Miss Muir retired in 1936. Hers had been a notable career starting with her training in Wairau hospital, then her appointments first as home sister at Christchurch in 1910, then ward sister and finally matron. Her chief achievement was the starting of the Nurses' School. The assistant matron, Miss Widdowson, then became matron.

In 1935 Dr Fox retired. He had resigned on several previous occasions and had withdrawn the resignation, but this one was final. It was accepted by the Board with the greatest

regret. His concept of retirement was to enjoy leisure that was relative but not absolute and he therefore agreed to fill the vacant position of medical officer at Little River. But the quiet of this place was too violent a contrast with the throb of hospital life and he soon fled back to town. In 1940 he was back in hospital, this time as military registrar. Dr A. D. Nelson became the new superintendent.

The Board in September 1932 approved the appointment of the Staff Executive. This has functioned ever since as a powerful body with a poor title. It is an advisory body only and has no executive powers. At the time of its formation it was recognised that many aspects of hospital work were so technical that the views of the medical staff were necessary and should be provided through approved channels and not through a minority who might be biased. These views were represented by the chairman who attended meetings of the Hospital Committee.

At the same meeting of the Board that approved of a Staff Executive an Appointments Advisory Committee was set up. Its function was to advise the Board on the qualifications of applicants. It, unlike the Staff Executive, is aptly named. It is purely advisory. The final appointment lies with the Board which on several occasions has decided against the advice of the committee. The setting up of the committee merely regularised what had been a common practice in the previous fifty years, not only in Christchurch but in other centres.

The depression of the thirties affected the Board more than it affected the hospital. The Board became a vast distributing agency for charitable aid and was limited to the general restrictions under which the whole country operated. (The North Canterbury Board expended nearly £218,000 on outdoor relief in the ten years following 1927). The Government refused to subsidise bequests, health patrols, district nurses and St Saviour's Orphanage. It attempted to transfer the responsibility for subsidising Mt Magdala from itself to the Board but was forced to desist in the face of a public storm of protest. It shelved the building of the Children's Home at Cashmere.

In 1931 there was a general wage cut of ten per cent. The emoluments of living in for the house surgeons and the free

house for the superintendent were assessed at £52 and £100 respectively and these were added to the actual salaries before the ten per cent was deducted. Five members of the maintenance staff (an electrician, fitter, carpenter, painter and labourer respectively) were dismissed. These measures resulted in a saving of over £10,000 but they were offset by the increasing percentage of patients' fees which had to be written off. The Board increased the radiotherapy fees, instituted a charge for venereal disease and raised the maternity fees from twelve to fifteen shillings a day. There was nothing masterly about this. The radiotherapy patients began to default in larger numbers, the attendance of venereal disease patients fell to half and a violent public reaction to the increased maternity fees forced the Board to revert to the original rate. Dr Shore of the Health Department advocated closing the country hospitals. This evoked in each instance strong local protest and the Board received either letters or deputations supported in writing or person by the respective doctors from Amuri (Dr Smale), Waikari (Dr S. Hunter), Oxford (Dr W. E. Minty) and Lincoln (Dr E. J. Cooke). The Board, always ready to defend these hospitals against the criticisms of Wellington, listened sympathetically and the hospitals were not closed. An economy committee of the Board met regularly. It left few stones unturned whether there was anything under them or not. One of its enactments was to reduce the weekly pocket money for the inmates of Tuarangi and the Jubilee Home from half a crown to two shillings.

It was an unhappy period. In the shadow of the privations came fear, mistrust and intolerance. One nurse died in hospital of miliary tuberculosis. It was a condition which at that time was invariably fatal, but the public preferred to think otherwise and sweeping charges of neglect and callousness were made against the hospital authorities, especially the matron, Miss Muir. Mrs McCombs, a member of the Board, pushed the charges. The Board set up a committee of enquiry which completely exonerated Miss Muir. In the evidence presented to the committee was a letter from the nurses eulogising the matron and containing 180 signatures. The Board closed the incident by commending Mrs McCombs for her courage and

by ordering that in future all nurses should be examined every six months by the medical superintendent. There were other complaints of mismanagement in the hospital, some of them originating from a certain section of the unemployed. They were all proved groundless but much harm was done by statements that were vicious and inaccurate and too often were sympathetically exploited by the press. In the catastrophe of war there is a high community morale because the enemy is known and can be met. In a depression the enemy is furtive and evasive, and is only too easily personalised by the fearful.

Even the Board was affected by the hesitancy of the times. Though Board members had for years represented all shades of political thought the routine work of the Board showed little evidence of this. But the question of salaries was a question of how to deal with the depression and was political. One section of the Board, prominent among which were Mrs McCombs and Rev. J. K. Archer, had opposed salary cuts at any stage and when they were outvoted worked strenuously for a restoration. Among their arguments were that some Boards had made no cuts at all and others had restored them much earlier. In 1933 a determined effort was made by Mr W. J. Walter to increase by five per cent the salaries of the lower-paid staff members. (A nurse in training got 7/3 per week). It failed and this prompted another unsuccessful motion that the Board had no faith in its finance committee. Another attempt by Mr Walter at the next Board meeting again failed to restore salaries but by only one vote. The Board had certain good reasons for being cautious. The national policy as represented by the Government was to approve expenditure only if it were inevitable. On one occasion in 1934 the Board secured through the Unemployment Board four carpenters to do some office renovations. The Hospital Board subsidised their relief wages to the award rate. This meant, said the Unemployment Board, that the men were not unemployed and the relief wages should not have been granted and had to be repaid. So the Hospital Board refunded £19 to the Unemployment Board. It was only the legislative compulsion of a special Act which permitted the building of the new Nurses' Home in 1931.

At this stage Mrs McCombs, who had proved herself to be

one of the wisest and most influential members of the Board, was elected to Parliament as representative for Lyttelton and retired from the Board. In March 1935 Mr Walter was at last successful. The five per cent restoration of salary was approved except for those who were working on full award rates. The Government refused to subsidise this increase and the local bodies had to be levied for a further £4800. In 1936 all wage cuts were restored to the 1931 basis. The depression was over.

And, as has been said, the actual effect on the hospital itself was comparatively light. All through the depression there was a very low incidence of infectious disease and the average death rate, incidence of tuberculosis and infant mortality throughout New Zealand were the lowest in the country's history. The deduction associating plain living with good health is obvious but not necessarily correct. There was not much gaiety in hospital. Some patients tended to stay longer as a preferable alternative to a bare home. The clinical, domestic and administrative work maintained its standard. The Board set a precedent and left a legacy of trouble for later Boards by acknowledging political factions.

The Social Security Act of 1938 was in the history of New Zealand hospitals second in importance only to the Act of 1885. The first act declared that landowners had a duty to the sick. The second act declared that the sick had a claim on the community. The social conscience was expanding and though the concession of free beds in July 1939 was in terms of money, the money was only the vehicle. The principle behind it was the more liberal one of recognising that citizenship carried privileges that were not jeopardised by physical ills. It was a bold adventure in social thought. (Only five years before there had been in Christchurch 234 cases of registered unemployed who, from their meagre allowances, had had deductions made for the support of dependants in orphanages, old people's homes and asylums). There resulted a satisfying simplicity of administration. The old routine of suspecting every admission of being an itinerant responsibility of another Board was gone. So went also the trespass into the wards of a member of the office staff, demanding statements of assets, promises of payments and signatures of consent. The contracts with the Lodges

for reduced but guaranteed fees disappeared overnight. In fact the change was too great for the public to grasp easily. Those who ordinarily would have been unable to pay were saved the humiliation of proving their penury. But those who could have paid were often embarrassed by the absence of any machinery whereby they could. Some doctors still remember those days and how the reluctance of many to accept free treatment tended to fill the private hospitals and confounded the gloomy prophecies that the public hospital would be swamped by irresponsibles.

The payment of part-time visiting staffs was first proposed by the Government. The public, hospital boards and the staff itself opposed it—a conflict without precedent. In 1938 the honorary staff of the Christchurch hospital passed a motion rejecting the idea of salaries. It was opposed by the public and the boards purely on the basis of extra expense, but their opposition was not strong nor was it even unanimous. To the Government it was a matter of simple justice. The labourer was worthy of his hire and honorary services by a learned profession would be a bad blight on the lusty plant of the welfare state. To the staff itself it was a matter of pure sentiment. The proud tradition of the profession was that it had never denied its services to the poor and it was loth to exchange its birth-right of benevolence for a mess of money. It was an altruistic outlook even if it was perhaps a little over dramatised. There was a secret fear in the profession that if payment was accepted the standard of work (always as practised by others) would fall. There was nothing new about the idea that staffs should be paid. Fifty years before the Christchurch *Press* had pointed out that doctors were finding it difficult to live on 'high ideals and bad debts' and several doctors in those early days went bankrupt. Gradually the opposition to payment lessened, and once the principle was admitted the staff began to study closely the salaries suggested. There were many meetings and enormous discussion, much of it ineffective as the final decisions were always made in Wellington. The doctors were soon forced into the paradoxical position that though salaries in principle were bad, yet in practice they should be adequate. Now the whole matter is covered by streamlined regulations standardised on

the sessional basis. There is no longer any opposition to payment. In fact it would be impossible with the changing pattern of medical practice for staffs to operate without salary. Hospital practice requires specialists and young specialists, particularly physicians, do not easily make a living. To give half their time to hospital practice on an honorary basis would make a livelihood impossible.

Salaries, far from lowering the standard of work, have raised it. A hospital appointment is a valued honour. Competition is vigorous and the training and preparation of applicants is thorough. The nature of medical practice is such that a keen doctor will always do keen work and cannot do otherwise. His concentration will be the better if his finances are sounder.

The Board nevertheless has taken precautions to preserve efficiency. Appointments are reviewed every three years and in a few instances have not been renewed. The hazards of age have been offset by a resolution of the Board in 1936 that members of the visiting staff must retire at sixty.

The second world war resulted in a lack of supplies, an elaborate scheme for large-scale civilian casualties, a fall in the birth rate, a freedom from epidemics and a shortage of manpower. Only essential building was done and this was confined to the extensions to wards 12 and 13 and to the expansion of Burwood hospital. Most of the medical staff went overseas and their places were usually filled by private practitioners often at considerable personal sacrifice. Some who stayed did so under the compulsion of the manpower authorities. The visiting staff that remained on the home front inaugurated a scheme of levying on their salaries and giving generous financial assistance to their colleagues who were overseas. There was also an acute shortage of nurses, both of trainees and seniors.

The wounded filtered back in small groups and were absorbed in the hospital, the sanatorium and in Burwood and no special military establishment was necessary. The smoothness of this reversion of the soldier to the civilian was largely due to the capable control. Sir Hugh Acland was A.D.M.S., Dr Hand Newton was regional deputy, Dr A. D. Nelson was superintendent. All these were old soldiers, wise in military

psychology. Dr Fox was military registrar and was as wise as any. In 1943 Dr Fox resigned on account of ill-health, made a rapid recovery and resumed work.

Nevertheless the Board had a host of troubles. In 1941 it was considering plans for building a new kitchen (which has not eventuated), new laundry, new theatres and extensions to wards 12 and 13. Shortage of men and materials meant that much of this had to be deferred. Dr Nelson who was at his best in troublous times by mixing judiciously conciliation and common sense with firmness, kept up a constant pressure for more bed space. From this grew the wards at Burwood and ultimately the fruit of his insistence was the Princess Margaret Hospital. As it became more and more difficult to satisfy the requirements for inpatients there was an increasing tendency to expand outpatients. It was in 1942 therefore that the Board bought the St Andrew's manse site and leased the Sunday School. The St Andrew's specialist outpatients was opened in 1944.

The war years saw the end of the long careers of a number of loyal servants of the hospital. Miss W. R. Norris, daughter of Mr T. C. Norris, had held in turn the positions of clerk, cashier, confidential secretary and hospital historian. She retired in 1941 after forty-two years' service. It was an extraordinary family career, unique in the annals of the hospital. Acknowledgment of the present writer's assistance from Miss Norris has already been made in the preface. In the same year Sister Oppenheim retired after twenty-seven years. Two years later Sister Jones appeared before the board at a morning tea farewell party and left with a sincere assurance of its gratitude for her thirty years of work and the tradition of discipline she had established in ward 7. Sister Randall retired at the same time. For the last period of her twenty-seven years in the hospital she had been supervising the domestic staff. Another resignation in 1940 was that of Miss Gates of Ashburton who for thirty-four years had voluntarily played the organ at the Sunday services at Tuarangi. In 1945 Sister Holderness terminated the thirty years of service during most of which she had been in *loco matris* to many thousands of children in ward 9.

Finally in 1945 Dr Fox died. He had dedicated his life to the

Christchurch hospital. When, over fifty years before, he had qualified at Glasgow he was recognised as a man with special ability. At that time Sir William McEwan had been appointed to a chair of surgery in America and he selected Dr Fox to go with him as his house surgeon. Eventually Sir William declined the appointment and Dr Fox began his travels. He held appointments in London, then New South Wales and finally Christchurch. His journeys always ended in the hospital. He drifted away from it at times for private practice, for farming and for country practice, but he always came back. He had been in turn house surgeon, honorary surgeon, honorary physician, medical superintendent, military registrar and consultant surgeon.

His prestige as a superintendent was not based on any single attribute. He was a loyal supporter of the honorary staff and the loyalty was reciprocated. He was equally the friend of the house surgeon although he was also a stern critic. In Dunedin the exuberance of the medical student tended to wilt under the steely eye of Professor Fitchett. The same student, qualified and in Christchurch, found a new freedom and was allowed to indulge it. But if his work suffered, a withering comment from Dr Fox would be a humiliating corrective. Yet those who worked and at times suffered under him never lost their affection for him.

The Hospital Board appreciated his special ability in administration. The hospital records reveal that many of the reforms initiated by the Board were first suggested by Dr Fox. In 1920 he wrote a long letter to the Board outlining an ambitious scheme for the post graduate training of nurses. It was going to be expensive and he enclosed his own cheque for £100. It fell through because the Department would not agree though most of the details are now in force in the post graduate school in Wellington. The following year he proposed a training school for hospital domestics but the Board considered it would be too difficult to administer. In 1921 he was the first to advocate registrars, a dietitian, the team system of a senior and a junior working in association. He was a vigorous supporter of the part-time staff, of the community hospital, of free treatment for venereal disease. He presented the Rose Muir

Medal for the nurse who came first in the Dominion, persuaded the Board to purchase a gas and oxygen machine, reorganised the nursing curriculum and started the economy campaign. It was because he so strongly identified himself with the administrative work of the hospital that the new post of assistant medical superintendent was created in 1923. The first appointment to this position was that of Mr L. A. Bennett who had previously been a house surgeon for over two years.

Like all good administrators he was also a good clinician. He was a very able surgeon and was always receptive to a new idea or a fresh advance. At the beginning of the century he published a number of articles in the *New Zealand Medical Journal* on such subjects as congenital intestinal malformation, surgical complications of typhoid, radical treatment of hernia and diseases of children.

Of the many tributes paid to his memory one of the most comprehensive was that published in *The Press* on April 28, 1945 by his friend, Dr T. A. MacGibbon. The report deals appreciatively with his early career, his influence on the nursing school and on house surgeons. It concludes :

'Dr Fox had a very large practice and was adored by his patients. Nothing was too much trouble for him and he was their friend as well as their doctor. When he gave up practice to live on his farm a public presentation was made to him, a rare event anywhere in New Zealand. The first world war brought him back into harness and, but for a brief time, he was Superintendent of the Public hospital from 1915 until he retired a few years ago. It was during these latter years I came to know him intimately. Anyone who was keen on his work for work's sake had his sympathy and active support. He was a great encourager of the younger medical man. He hated the slacker and the commercial practitioner and liked to see the seniors giving a helping hand to the beginners. In short Dr Fox was an example of all that is best in the Scottish medical man. The hospital was his life's work and pride. . . . Generations of nurses and many former house surgeons will bless the name of "Daddy" Fox for they owe him much.'

The divisions of this history are arbitrary but not artificial. This section closes inevitably with the death of Dr Fox and the end of the second world war.

CHAPTER FOURTEEN

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Physiotherapy and Orthopaedics

PHYSIOTHERAPY

THE PHYSIOTHERAPY DEPARTMENT BECAME FIRMLY ESTABLISHED during and as a result of the first war. True, the scouts had for long been out exploring the field. A Mr Gardner had been appointed in 1887 as honorary galvanist and Mr Hilson had for the two years following 1893 been honorary masseur. After a twelve year vacancy this position was again filled by Mr Hornbrook in 1907 who resigned six years later. He had no premises, worked in the wards and when he complained of lack of privacy was given an extra screen. In 1912 the staff recommended that the appointment should be a paid one. The Board agreed and selected Miss Allbrecht, then Miss Petersen and in 1913 Mr Sarelius who got £100 a year for working three hours a day for six days a week. Two years later when the administration block was built the first physiotherapy premises were reserved—a small area where is now the house surgeons' dining room and kitchen. Mr Sarelius resigned in 1917 and his two assistants (Miss Burbury and Miss Dixon) comprised the remaining staff.

This modest establishment might have continued indefinitely had it not been for the arrival in Christchurch in June 1918 of Colonel Valentine, Director of military hospitals, claiming audience with the Board. This secured he told his dramatic tale.

He reminded the Board of the special orthopaedic units that had been trained in England under Sir Robert Jones and that two of these were designed for New Zealand. The first, trained at Shepherd's Bush and commanded by Colonel Wylie was a complete and fully equipped establishment with surgeons,

sisters, physiotherapists, orderlies, technicians and all the apparatus and supplies for splints, plaster and artificial limbs. This unit was now on its way back. Its arrival was imminent and a decision had had to be made as to where in New Zealand it was to be accommodated, and this had been done. It was to be accommodated in the Christchurch hospital.

In the silence in the Board room that followed this announcement Colonel Valentine hurried on. Two hundred beds. A hundred and twenty in the new Chalmers block. Yes, Miss Chalmers had agreed in writing to this. Temporary wards for the others. Administrative rooms, a splint department, a massage department and masseuses. Great shortage of masseuses and the Board would have to train some of its sisters. Ward 4 would have to stay up. Other buildings would have to go up. Costs shared. Army would help the Board to help the Army. Urgent. War.

The Board, saved by this urgency from a slow analysis of the conflicts of policy, poverty, pride and patriotism, agreed in principle to the proposals and set up the inevitable subcommittee. It was Dr Fox who drew up the original plan and the final one differed little from this. The etiquette of administration raised some nice points. The soldiers were the dependents of the Defence Department, the property of General Russell, the patients of Colonel Wylie and the responsibility of the hospital Board.

When building started it went ahead rapidly. The plans called for two new wards. These wards (later 14 and 15) were erected behind the old offices, close to ward 4 and yet far enough distant to allow the Board to pull down ward 4 if necessary. They were wooden, temporary, cheap, barren of adornment and almost barren of facilities and were to accommodate sixty patients. But these were only for the patients of a unit and the unit itself required much more space and, on the space, buildings. Two sites were chosen, one between wards 4 and 5 and the other between 5 and 6. Each was to run the full length of the wards and to be twenty-five feet wide. The one between 5 and 6 was to be for 'the baths, electrotherapeutic and balneological rooms', or in a more modern phrasing the physiotherapy department. They were built by Mr J. L.

Gant at the contract price of £1798 to which the Defence Department contributed £500.

The next problem was accommodation for medical officers of the unit. The first suggestion was to build another storey on the old residency in front of ward 4, and the Defence Department was to find another £500 for this. All this had something a little unreal about it, as if the unit was to be consolidated on a permanent basis. When it was realised that by the time the new accommodation would have been built for the officers there would probably be no officers left the scheme was abandoned in favour of modifying the old residence for living, dining and administrative functions. This was done and the title of A.D.M.S. (Assistant Director of Medical Services) has persisted ever since. Extra accommodation for nurses was found at 35 Cambridge Terrace. The actual increase in nursing staff was only 25 as much of the work was done by orderlies. The old Board room and administrative offices were extended towards the Chalmers block and transformed into a splint room and still remain as such. A plaster room and a basket-work room were established in the vicinity of the splint room. The military unit used the hospital's theatres, X-rays and pathology services. The hospital masseuses were absorbed into the military unit and the masseuses in training were attached.

The physiotherapy department thus became a secondary unit of the orthopaedic unit. It was commanded by Major Stanley Wallis, and staffed by Sister Christine Smith in charge, assisted by Sisters McKegg, Clark and Christmas.

Though there were a large number of soldiers in Chalmers block in the latter half of 1918 it was not till 1919 that the unit began to function as had been planned. In Chalmers were the privates. In the new block upstairs (later 14) were the N.C.O.'s. Downstairs (now 15) were officers. And, strategically placed with an eye on them all, was the A.D.M.S. The Defence Department paid five shillings a day maintenance for each soldier. The control was a purely military one under Colonel Wylie and his successors, Colonel Hand Newton, Colonel Acland and Colonel Fenwick—a little army isle in a civil sea. But there was no siege. The relations were very cordial. Civil

operations were done in the morning and military ones in the afternoon and the same theatre staff and anaesthetists were employed at both times. It was an arrangement with mutual benefit. The civilian doctors had much to learn about orthopaedics. The military officers, many of whom had gone straight into the army after graduation, had everything to learn about civilian practice. Smooth co-operation was evident during one Christmas when there was a misunderstanding over leave and military officers were astonished to find on returning that for ten days the military hospital had been completely managed by one junior civilian house surgeon.

The second New Zealand orthopaedic unit was also trained in England partly at Shepherd's Bush and partly at Alder Hey. On arrival in New Zealand it was dispersed to various centres. The most important contribution to Christchurch was Captain Leslie Will, who took over from Major Stanley Wallis.

The soldiers came and went as is the habit of soldiers, and rapidly the numbers dwindled. In 1920 it was obvious that the orthopaedic unit would before long have to capitulate and abandon its territory. The staff approached the Board requesting that the essential features of the orthopaedic department should be retained for civilian purposes. By March 1920 the retreat was sounding. The remaining soldiers were grouped in ward 2. The temporary buildings were handed back (free) to the Board to commence their long career of permanency. On the eve of reverting to civil control the soldiers made a formal protest against the loss of privileges that would ensue. They wanted their special gate left open at the side of Chalmers block where their leave passes were checked. The Board said it did not approve of retaining this at a cost of £500 a year when the ordinary entrance through the administration block required no passes at all. The soldiers also protested at losing their superior scale of military rations. The Board replied that all the food was cooked in the same kitchen and there never had been a superior scale of military rations. By June 1920 civil control of soldiers was effected. There were left 64 patients whose fees, guaranteed by the Army, netted the Board almost as much as those of the 268 civilians. Captain Will remained on loan to the physiotherapy department. Its staff was reduced

from seven to five. It began to take private cases and has done so ever since.

By this method the physiotherapy department was born. It was of civilian and military parentage and was adopted by the hospital as a foster child. It became marked for a permanent role on a civilian basis.

In 1921 Dr Will returned to England and control of the department passed to Dr Fox. In 1922 Sister Jean Irwin, one of the survivors of the *Marquette* disaster, became the senior masseuse. Her predecessors had been Sister Clark and Sister Smith.

The work decreased during the depression as it was neither urgent nor free. It expanded again rapidly after 1935 as the toll of industry and traffic increased. The department now gives over 60,000 treatments a year.

In 1947 Dr Will, at the request of the staff, was again put in charge and the senior orthopaedic surgeon has always controlled it since. Sister Irwin retired in 1947 after twenty five loyal and efficient years. She was followed by Miss Adams and then Miss Derbidge who holds the present appointment. Both Sister Irwin and Miss Derbidge had interruptions of several years in their service, the former for war duties and the latter for post-graduate studies. Their places in these intervals were filled by Miss J. Jennings and Miss M. L. K. Sams respectively.

THE DEPARTMENT OF ORTHOPAEDICS

During the last century all orthopaedic work was performed by general surgeons. In effect some of these were orthopaedic surgeons in that they were intimidated by the surgical approach to other regions and so were restricted to the limbs. They were not necessarily good surgeons and their final resort in an awkward case was always amputation.

The orthopaedic department was formed on the basis of the old military orthopaedic unit. The architect and builder was Dr J. Leslie Will. When the military unit disbanded he was lent by the Defence Department to supervise the splint shop.

He entered into an agreement with the Board to go to England for post-graduate work and, on his return, to become orthopaedic officer to the hospital at a salary of £850 a year. This was done and he resumed in 1922. From this date the hospital had an orthopaedic department.

From the administration point of view it was a very scattered department. The splint section which had originally been in the charge of a sergeant, was now controlled by Mr G. Challis, the first civilian appointee. Sister Beswick presided over the plaster room which, shortly afterwards, was shifted to a small room near the dispensary but was then transferred to a verandah on the far side of the outpatients' waiting room opposite the morgue and remained there till 1940. The vacating of this first plaster room and the cessation of activities in the gymnasium allowed the X-ray department to move into what then became its permanent quarters. The artificial limb section which had been formed after the military hospital was established reverted to the Board in 1922, the stock and tools of both this and the splint department being taken over at valuation. In this unit wooden limbs which had been supplied by the McKay Artificial Limb Company of Australia were modified and fitted. But in 1924 the Defence Department, without prior notification to the Board, began making metal limbs in Wellington. Instead of closing down this work the Board secured the services of an Australian authority who was in Christchurch (Mr Ryan) and he instructed the staff in the new methods. Mr A. Shipman was appointed to be limb maker in place of Mr Hart. These then, along with physiotherapy, were the components of Dr Will's new territory. He consolidated it by adding an orthopaedic outpatient department.

Dr Will's contract with the Board served its purpose by permitting the department to be established. But thereafter it was difficult to maintain against the Board's forced economy and Dr Will's energy and ambition. Before long it was modified whereby he worked half time at the hospital and the rest at private practice. But in 1929 his stipend stopped and he became an honorary orthopaedic surgeon. This involved loss of direct control over the physiotherapy department though

such control was restored in 1937. At this same time an orthopaedic house surgeon was appointed.

For a long time it was difficult to convince all the general surgeons that orthopaedics could be justified as a specialty. They regarded most orthopaedic procedures as being within their range although they admitted a few exceptions, but there was no agreement on what were the exceptions. The pursuit of a formula that would satisfy everyone occupied many medical meetings particularly of the staff executive. Finally it was agreed that the orthopaedic surgeon should be responsible for a full fracture service. During the second war those responsible for the Emergency Precautions scheme were uneasy over the potentialities of the orthopaedic department in the event of invasion. There resulted then a comprehensive extension of the department. A new building was constructed on the north side of the old corridor. It included a gymnasium and two minor operating theatres, one for plaster work and one, equipped with a portable X-ray, for other procedures. The old verandah previously used for plaster was vacated and was then converted into small rooms used by specialist outpatients until St Andrews outpatient clinic was established. The expected battle casualties arrived but in no great numbers. They were allotted to ward 2 and were easily controlled by the orthopaedic staff. All the drama of the first war was absent. But the injuries that did not come with war came with the peace. The population increased. So did industry, sport and the toll of the road. Further extensions were made. They included a complete separate plaster unit at first under the charge of Sister Gilchrist and later Sister Henderson. Another X-ray was provided and then two minor theatres for fractures, each with its own X-ray.

As the facilities increased so did the scope. The department in 1949 began a 24-hour emergency service. Its outpatient service was independent of the rest of the hospital. It made its own diagnoses, took and interpreted its own X-rays and treated by its own methods. This independence existed until 1961 when an initial screening of its patients began in the Accident and Emergency ward.

During this long period staff changes have been inevitable.

Mr Challis, never flagging in his inventiveness or his quick energy, retired in 1955 after thirty-five years' service. He was succeeded by Mr A. R. Gavan who was appointed at the same time and whose retirement in 1958 establishes the record in time for the department. Despite his quiet proficiency in the splint department he had been a close observer of the hospital scene, and this history is indebted in part to his confident memories. The rehabilitation centre at Riccarton began making artificial limbs after the war and this work diminished at the hospital and finally ceased in 1957. The orthopaedic senior surgeon, however, is responsible for the orthopaedic advice at the centre.

In 1956 Dr Will retired. The department he created and left so soundly based is his memorial. His objectives were always attained by quiet sincerity and no aggressiveness and he still has, as he has always had, the deep respect and regard of his colleagues. During the war he was assisted by the first full-time orthopaedic surgeon, Mr Lindsay McDougall. He was followed by Mr Rex Blunden who, on Dr Will's retirement, became head of the department. Mr Blunden and Mr A. B. McKenzie are now the senior orthopaedic surgeons while Mr W. A. Liddell is an assistant. All three surgeons are members of the visiting staff. The full time appointment of Mr S. M. Cameron as assistant orthopaedic surgeon was made in 1962.

There remains for further comment the last legacy of the old military unit of 1918, namely the temporary wards between ward 4 and the Chalmers block. These became in effect a nurses' home in that difficult period of the late twenties when the building of a new home was being continually delayed. The upper floor was a dormitory. Below was a kitchen in the annexe on the left as one enters the corridor, while the main portion was a nurses' dining room with a smaller one on the right for sisters. When the nurses' home was built all this was vacated. The ground floor then became the Board's store and distributing office during the depression. When this became unnecessary after the depression the Board used the place as a bulk storehouse. But the final claim is always made by patients. When in the late thirties there was a severe epidemic of poliomyelitis it became necessary to find new wards, capable of

being isolated. These buildings were selected and for the first time they achieved the dignity of being named wards 14 on the top floor and 15 below. After the epidemic came the war and the bed space was so short that it was impossible to close them again. It was not till Princess Margaret hospital opened in 1959 that it was possible to clear ward 14 of patients. After filling some minor roles, including the entirely novel one of being unoccupied, it was selected as the first premises of the Medical Centre. Ward 15 was taken over in part by the Occupational Therapy Department which previously had been crowded into a restricted area near the cafeteria. The rest of the ward was modified into a gymnasium for severely handicapped children (1962). This is pioneer work, too recent for appraisal. But the results are encouraging and other hospitals as well as the Health Department are watching the experiment with interest and approval.

CHAPTER FIFTEEN

1874/75

The Expanse of Pathology

THE STUDY OF PATHOLOGY WAS SOUNDLY BASED IN THE Christchurch hospital long before it was housed in a department. It lacked equipment but it can often forego equipment. (A few years after the province was founded a coroner in Lyttelton ordered a post mortem in a case of suspected poisoning. The two doctors so instructed fed the contents of the stomach to four dogs all of which died.) A special committee of the Provincial Government in 1870 advocated (unsuccessfully) a pathologist. Dr Guthrie in 1876 proposed (unsuccessfully) a pathology museum in the new A.D.M.S. The Board at an early stage had a microscope of obscure origin and purchased a stand for it (£3) in 1894.

The interest of the doctors in pathology was genuine and productive. For instance though the condition of myocardial infarction was not fully described clinically till this century the records prove that some of the early Canterbury doctors were travelling close to the truth. In 1873 Dr McDonald did a post mortem on a man who had died with the typical symptoms of an infarction. He ascribed death to 'mechanical obstruction of the heart's action'. In 1887 Dr Guthrie demonstrated a heart showing 'extensive atheromatous degeneration of the aorta and valves and coronary arteries'. Shortly after, another heart was the subject of a B.M.A. discussion when surprise was expressed that though death was sudden there was no coronary atheroma.

In 1898 Dr Campbell at a B.M.A. meeting moved that the Board be asked to set up a pathology department. It then transpired that the Board at the urging of Dr Fox had been

for some time in communication with the Wellington Board which had just appointed Dr Fyfe as its first bacteriologist. The Board became satisfied that the Wellington scheme was too costly. Dr Fox was not satisfied. All Christchurch wanted was £50 worth of equipment and permission to go ahead. The Board gave both. The apparatus arrived in 1899. A corner of the dispensary was fitted up as a laboratory and any member of the staff was free to work there if he was sufficiently competent in the technique.

But few were, and more and more specimens were sent to the medical school in Dunedin. In 1907 Drs Acland and Stevenson urged on the Board the necessity of a bacteriologist. The obvious man was Dr M. G. Louisson, late acting bacteriologist at Guy's hospital. All that was needed was another £50 of equipment and better quarters.

The Board agreed and a laboratory was established in the recently vacated old operating theatre. Dr Louisson began work. He could cope with only a small portion of it. His position was honorary and he had to make up his own media. A second assistant house surgeon was appointed to help. He dealt with bacteriology only. All pathology specimens went to Dunedin.

Then in 1911 the Board agreed to appoint a full time bacteriologist and pathologist. Professor Champtaloup of Dunedin was consulted. He advised on a reorganisation of the laboratory and then suggested that the position might be offered to a certain young Edinburgh graduate whom he would strongly recommend. The Board agreed and in July 1912 Dr A. B. Pearson, with a salary of £500 a year, began his life's work in the Christchurch hospital. Dr Louisson retired with the sincere and well merited thanks of the Board.

For over thirty years Dr Pearson was to be the loyal servant of the hospital. He kept abreast of an ever expanding subject and in some instances led it. Though at the end he was surrounded by young and keen men, he was with them in thought and could more than match them in wisdom. He was implicitly trusted by the legal profession as an authority in forensic medicine. He was external examiner at Otago in this subject for ten years and in pathology and bacteriology for

thirty years. He was self effacing, had no enemies, was tireless in helping others, and served the hospital better than in some ways the hospital served him.

The day Dr Pearson arrived at his new hospital he was greeted by the superintendent whose first question was when could he start? Before answering this he inspected the laboratory. It was dingy, crowded, had been used more or less as a lumber room and was filthy. The equipment was an incubator, a microscope, an autoclave and an iron saucepan for sterilising. Dr Pearson cleaned up the laboratory and then proceeded to clean up the hospital. There was a diphtheria carrier in the hospital, so he was told, causing frequent infections among the staff. He was asked to look into the matter. He did and reported that the infection came from a certain patient who had a chronic tuberculous sinus. The staff, a little sceptical at this migration of the diphtheria bacillus, were yet cautious enough to treat the sinus with isolation. The epidemic stopped. The new pathologist was on his way. After the first two months he reported to the Board that he had performed the following examinations for hospital patients. (Additional cases for outside practitioners given in parentheses.)

Sputa 16 (15); Diphtheria swabs (81) (9); Morbid exudates 33 (23); Blood examinations including Widal tests 9 (10); Tumours 4 (9); Vaccines 10 (5); Urinalyses 14 (21); Faeces 0 (2).

The private cases were all charged to the appropriate doctors who then tried to recover the fee from the patient—and sometimes succeeded. Swabs were five shillings each and diphtheria swabs and typhoid agglutinations were six shillings. Not more than two or three post mortems were done each month, usually at the request of the coroner.

Indefatigable as Dr Pearson was he could not deal with the increasing work. The Board tried unsuccessfully to get a technician in New Zealand and in 1913 investigated overseas and secured the services of Mr T. Ross, paying his fare from England and giving him a salary of £150. Mr Ross, a most capable bacteriologist, also was to spend the rest of his professional life at the Christchurch Hospital.

The chaos of war inevitably spread to the Pathology Department. It reached its climax in 1916 when at one stage Dr

Pearson was in Auckland investigating typhoid on the hospital ship and Mr Ross was in Featherston investigating meningitis. Despite this the Department was closed for only two days and has never closed since. The monthly reports to the Board were a few lines tersely summarising the work done and on some occasions there was no report at all. The Board could not help as there was no trained staff available in the country. It did, however, give valuable assistance in 1916 by appointing a typiste. The next year the army sent a medical corps private to give what assistance he could. The understaffing was the more regrettable because when the administration block was opened in 1915 the Pathology Department was moved to the second floor where it had four rooms and was at last able to breathe.

Dr Pearson's five-year term of office expired in 1917 and the Board tried to re-engage him at a salary of £650 instead of the original £500. With one of his rare gestures of independence Dr Pearson refused and without any further discussion the Board proposed £950 a year for three years. This was accepted. The Board could run no risk of losing him. He was still the only full-time pathologist in New Zealand, although there were several bacteriologists. Also during the war there were large epidemics and at one stage the hospital had eighty cases of diphtheria. When Mr Ross was demobilised he was also reappointed at a salary of £375. In 1920 when Dr Pearson went to England the Department continued under Mr Ross, some assistance being given by Dr C. E. Hercus, then studying for the D.P.H.

After Dr Pearson's return the Department rapidly expanded. In 1921 its quarters were extended and in 1926 when the top storey was built on the administration block the Dental department went upstairs and the Pathology department moved into the vacant premises. In 1923 Dr Milligan was appointed as the first biochemist. His interest was mainly in diabetes which at last was capable of effective treatment after Banting's discovery of insulin in 1919. There was now a steady increase of technicians. Some nurses went into the laboratory and after a course of training were transferred to smaller hospitals as bacteriologists. A museum of pathology was started and in 1922

the B.M.A. gave £10 for glassware for specimens. More and more use was being made of the department. Dr Pearson had for a long time run a vaccine outpatient service. He then added an allergy clinic. In the meantime Dr Milligan conducted a diabetic clinic.

There was an increased amount of post mortem work. Every city must have access to a morgue and so must every hospital, but the duplication is often unnecessary and wasteful. When the Christchurch City Council morgue therefore was destroyed by fire it was agreed that hospital and city should combine in a new morgue. The hospital one, approximately on the same site as the present one, was a miserable structure, even for a morgue. It was always known as 'the dead house'. The new morgue was to have suitable provisions for post mortem examinations, a room for inquests, and a small chapel. The tender was let to Mr J. Taylor in 1918 (£2330, of which the City Council paid one third). It was first used in November 1919. (The inscriptions on the two morgues illustrate the sad effects of the neglect of classical education. Over the door of the old morgue was *Sanitas ex morte*. On the side wall of the new morgue was 'Main exit'.)

During the depression there was no expansion of premises or staff, and the work, owing to the absence of epidemics and the difficulty of private fees, did decrease somewhat. In 1927, Dr Pearson reported over 20,000 examinations for the year. Dr Milligan at this time applied to the Board for recognition of independent status as a biochemist, but this was declined. The staff at this time consisted of Dr Pearson, Dr Milligan, Mr Ross, a technician, a typiste, a porter and five female technicians.

Then came the sensational dismissal of Dr Milligan. In 1929 the Board, acting on the recommendation of the Hospital Committee, gave him three months' notice. It was bitterly contested by the Board, especially by the Labour members led by Mrs McCombs. The motive, it was claimed, was economy but other reasons weighed. Dr Milligan was an individualist who was more interested in research than in clinical medicine. His work was mainly with diabetes and goitre, both of which through recent advances had become minor specialties. He did not

claim to be a pathologist and consequently his appointment had in very small degree relieved the burden on Dr Pearson. The latter was contemplating a voyage to England and wished for a pathologist who could deputise in his absence and assist on his return. The supporters of Dr Milligan contended that this could still be done without unseating Dr Milligan.

The protest went far beyond the Board. Numerous signed letters appeared in the papers and the local Labour Party recorded its disgust at the Board's action. No letters appeared supporting the Board. It was evident that Dr Milligan had many friends and there was much admiration for anyone who was pioneering research. But the support of the public lasts only as long as the interest of the public. Fresh headlines appeared in the papers, the letters ceased and Dr Milligan left the hospital.

In retrospect there were no special villains in the piece. Dr Milligan cannot be blamed for wanting to do work in which he was particularly interested which he, more than anyone else, realised was important and which he could do well. Dr Pearson could not be blamed for having asked for assistance and then, years later, pointing out that what he had been given was not what he had requested. The Board could not be entirely blamed because it was undoubtedly acting under pressure. Much of the pressure came from the honorary staff which to some extent shared the general practitioners' mistrust of private patients being lured off to hospital clinics. Perhaps the main blame should rest on the troubled times of the depression.

Dr Milligan went into private practice as a clinical biochemist and for many years in Christchurch was loyally supported by the public, especially the diabetics. At present he is living in retirement in Tauranga.

The new assistant pathologist was Dr Edgar Thomson. He controlled the Department while Dr Pearson went to England. The latter was given eight months' leave on full pay conditional on his promise to return and resume his duties. He went with the hearty good wishes of the Board and also of Dr Valentine, the Director-General of Health, who wrote to the Board approving its action and paying a tribute to Dr Pearson's services, not only to Canterbury but to the whole Dominion.

Dr Thomson, highly skilled, genial and popular, served five years and then was appointed bacteriologist to the Royal Prince Alfred Hospital, Sydney. He was followed by Dr C. J. C. Britton, whose special interest was in haematology and who, in partnership with Sir Lionel Whitby, had just published the best English text book on blood diseases. He was an able and willing teacher but he is remembered better for his work in connection with the library. After two and a half years he resigned and went to London, where he has had a brilliant career as a clinical pathologist.

For three months the vacancy was filled by Dr D. N. Epstein, who was a young and able surgeon whose short career was terminated by his sudden death in 1937. Then Dr Thomson returned from Sydney but after two years was again appointed to the Royal Prince Alfred Hospital, this time as assistant pathologist. Once more he was treated to a farewell and a presentation from the staff with a warning that any future re-appointment would be welcome but any future presentations were not to be considered. Dr Thomson has since attained considerable eminence in the profession in Australia.

The new assistant pathologist in 1939 was Dr Denis Stewart, who shortly after went on active service. Dr K. F. Uttley took his place, resigning in 1945 to become pathologist at Timaru hospital.

During the second world war the Pathology Department became something far greater than a laboratory of test and experiment. It set an ideal of loyalty and selflessness that no other department could match, proud as their records may be. Dr Pearson and Dr Uttley managed all through the war, battling against a sea of troubles. One by one the technicians went on active service and trained replacements were almost impossible. To maintain that minimum help that would prevent a breakdown, married women with decreasing family responsibilities were employed, as were nurses, medical students, medical corps orderlies, a retired typist and a volunteer technician from the radiotherapy department who filled both positions. For the first time in New Zealand venepunctures were entrusted to technicians. There was a serious shortage of equipment. After much delay one order was despatched from England and

was lost by enemy action. For the two years preceding Pearl Harbour Dr Pearson tried unsuccessfully to get supplies from Japan.

Shortage of staff and equipment could perhaps have been met by a reduction of work but the circumstances of war led both to an increased volume of requests and a widening of the scope. Dr Pearson's special clinics—the first in New Zealand to be conducted from a pathology department—were steadily maintained during the war. The medical practitioners in the city, depleted in numbers and overworked, were forced to use his clinic more and more and to resort in their diagnostic dilemmas to the laboratory test.

The main increase in work, however, concerned the matter of blood transfusion. For many years the surgeon faced with a transfusion selected a likely relative and did cross typing. Dr Thomson started a blood transfusion service. In turn Dr Stewart and Dr Uttley continued the work. During the war a Canterbury branch of the National Blood Transfusion Service was formed with Commander C. H. Kersley as secretary. It is a service that has never lacked public support and even by 1940 there were 250 donors. The blood bank was established by Dr Uttley in 1940. Dr Pearson both welcomed and feared this. In the early transfusions many patients had disturbing reactions and he felt that there were dangers in processing blood when the space was cramped and the risk of contamination great. He asked the Board for a separate blood transfusion unit. This was granted in 1942. The Board room was given up for the purpose and two technicians were appointed to work under Dr Uttley. Thereafter the Board held its meetings in the library. The transfusion unit was steadily expanded and now deals with all intravenous fluids. Through it blood is available to private practitioners and to other hospitals in Canterbury. The transfusion service is a lay organisation controlled by a committee of which Dr R. C. S. Dick has been chairman for some years. Both it and the transfusion unit in the hospital are dependent one on the other. Since Dr Gunz was appointed as haematologist in 1950 he has been in charge and now has a staff of seven. The service has a long and loyal list of donors and its access to them was greatly improved in 1954 when a

mobile transfusion unit was purchased, largely by means of a cheque for £1500 from the Junior Chamber of Commerce, and a subsidy of £1000 from the Board. In 1958 the unit bled over 8,000 donors, issued over 6,000 bottles of blood and prepared more than 21,000 bottles of other solutions.

The war brought other increased duties. The inoculation, vaccination and blood grouping of soldiers was done by the department. Penicillin first became available for civilian use in 1944 and its distribution was rigidly controlled and entrusted to the pathologists. The Health Department added the responsibility for the analysis of the city's water and milk supplies. The biological tests involving the use of live animals increased in number.

These last were responsible for the only additional building in the department during the war. In 1944 an animal farm was created out at Marshlands, mainly for the purpose of breeding and maintaining an adequate supply. For animals actually under test an animal house was built on top of the morgue. At the same time two more rooms were constructed for the histology section. These additions cost £2000 and, at a time of great housing shortage, the public were critical. An editorial in one of the papers, apparently under the impression that all the money was spent on the animal house, asserted that the cost was too much for sixteen guinea pigs and twenty rabbits, all of whom had a short expectation of life.

Just as the department became a symbol of loyalty to the hospital, so did the hospital show loyalty to Dr Pearson. He was trusted and respected by the Board to a greater degree than any previous staff member. That his facilities were not further increased during the war was not because the Board was indifferent to his needs. He and Dr Fox were close friends, all the closer because the friendship could survive criticism of each by the other.

There was also loyalty within the department. One source of this was the smooth working of the biochemical laboratory. In 1936 when Miss McDonald was appointed to Greymouth hospital the vacancy was filled by Mr J. T. Murray, then a young man but one who was an M.Sc. with first class honours in chemistry. Mr Murray took over the biochemistry depart-

ment and has maintained it since. It is now an indispensable part of the hospital services. Mr Murray is an enthusiast and carries his enthusiasm to the staff. He has always kept in close touch with the clinicians and by this means some important progress has been made, particularly in work on electrolytes. In 1947 he was granted the title of Hospital Biochemist. Though still in mid-career he has already earned an honoured place in hospital history. This was recognised in 1958 when the Health Department granted him a special grading. In the previous year he and his three assistants with some bacteriological trainees carried out over 30,000 examinations. For many years in his annual reports Dr Pearson referred with deep satisfaction to the administrative co-operation and the technical efficiency of the biochemical laboratory.

Senior among the veterans of the department was Mr T. Ross, the senior technician. He and Dr Pearson were students together in the laboratory in Edinburgh. An agreement to continue working together, if possible, was then made and was ratified when in 1913, less than a year after Dr Pearson was appointed, Mr Ross joined the department in Christchurch. For many years these two were the basis of the staff. Dr Pearson, in a tribute to Mr Ross, said: 'We worked hard. Saturdays and Sundays were very little different from week days. It did not matter to Tom Ross. He was always a willing and cheerful worker. No man could wish to have a more loyal assistant.' Mr Ross continued working up to the day before his death in 1948. Another veteran was Miss Prins, daughter of the previous house surgeon in 1864. She retired in 1945 after thirty years in the department, during the latter part of which she had been in charge of the vaccines.

The war ended. Men began to return and relief was at last in sight as far as the staff went. It came a little too late for Dr Pearson who collapsed with a heart attack and entered hospital. His absence however was only temporary and in the interval the department was controlled by Dr Stewart who had just returned from military service. In 1948 Dr G. C. T. Burns, a previous house surgeon, returned from active service and also from London where he had obtained the Diploma of Clinical Pathology, and became the hospital microbiologist. Dr Gunz

was appointed in 1950. He was a graduate of Cambridge, was very well qualified, and after some initial opposition from the Health Department became the first full time haematologist in New Zealand.

At the end of the forties an era was closing. Dr Pearson was in poor health and Dr Stewart who in 1947 had gone to England for post graduate work returned hastily by air. In June 1949 Dr Pearson retired. Dr Stewart became the new Director of pathology services. Dr Pearson, unable to conceive of leisure in terms of idleness, joined his son Dr Colin Pearson in a partnership of private clinical pathology. He worked up to his death in 1953.

He left behind him a record of service which in the opinion of many could not be equalled and in the opinion of most could not be excelled. He did not need to strive for the qualities of his greatness for they were inherent in him. His energy never failed, his enthusiasm did not flag. His knowledge grew and his wisdom widened. His kindly personality excluded all enemies. In 1934 when salaries all over the country were being pared he was granted a bonus of £50 by the Board in defiance of the Health Department. He had ample evidence of the esteem in which he was held by the Board, the medical profession, the Departments of Health and Justice. On his retirement he was awarded the C.B.E. After his death the New Zealand Society of Pathologists commemorated him by founding the A. B. Pearson Memorial oration. But the most enduring tribute is the simple history of his department starting with some odd pieces of metalware on a bench in the dispensary and in 1945, the year before free pathology services were introduced, producing a volume of work for which the fees were £10,000.

As one era closed another opened and that one is barely launched and its history is of the future. It started by realising one of the dreams of Dr Pearson of breaking the department up into its own specialties. Dr Stewart became responsible for histology, Dr Burns for microbiology and Dr Gunz for haematology. (These last two specialties were changed from departmental titles to hospital titles in 1961.) To expand the work of Mr Murray a chemical pathologist has been approved in

principle even if not yet discovered in person. In 1961 the previous assistant pathologist at Christchurch, Dr A. F. Burry, was confirmed in his appointment as pathologist to Princess Margaret hospital. Dr R. F. Hough, a previous registrar, is now a junior specialist pathologist at Christchurch.

This delegation of authority is what Dr Pearson would have done if he had had the staff. The scope of the work is now changing. Other hospitals, the civic authorities, the departments of Justice and of Health, now depend on the Pathology department which, in addition to supplying a need of the hospital, is permitting the hospital to supply a need of the public. The technical administration of the pathology services at the other two main hospitals is controlled from Christchurch. Much of the clinical work has gone to specialists' outpatients and yet the Department is keeping in the closest touch with the clinician. Like the Radiology department, the Pathology department is constantly stimulating and alerting the physician and surgeon. At the clinico-pathological conferences the clinicians and pathologists meet on common ground, tilt with each other's weapons and part with mutual respect.

The academic advances in the Department have been much greater than the architectural ones. Despite innumerable interior modifications the area has until recently remained constant for twenty years. But in 1960 the Department took over the premises of the library. The move for a long time was opposed by the medical staff. But the opposition ceased as the realisation grew that the claims of the library were those of convenience while the claims of the Department were those of necessity. It is not easy to resist essential requirements in a department which has a staff of nearly sixty, working under eight doctors and performing almost 200,000 items of work each year.

CHAPTER SIXTEEN

62/1/29

Concerning Dentistry

DENTISTRY, THAT LONELY COUSIN OF MEDICINE, WAS FIRST represented in hospital in 1894 by Mr E. Turrell, whom the Board hesitatingly permitted to work in the wards without staff, offices, salary or equipment other than his own. There must have been some obscure satisfaction in this because he was reappointed at intervals and when he retired in 1901 there were six applicants for the position, the successful one being Mr A. L. Myers.

For nearly a decade Mr Myers worked under the same conditions with the occasional diversion of a short gas anaesthetic for a surgeon. In 1906 a deputation from the Christchurch Odontological Society (Messrs Myers, Newell, Pritchard and Jones) waited on the Board and urged the formation of a Dental Department. It asked for a room, a nurse, equipment worth £50 and the right for its members to provide a free service. The Board at a time when the hospital was packed as tight as a wool bale found a room impossible and referred the matter to the staff. Was a dental room necessary? No, said the staff, but a dental ward was. The Board was amused and passed on to the next business.

When the more progressive Board of 1910 was in power Mr Myers tried again, stressing the necessity for conservation work with children. He failed to get his room but did get a sympathetic promise that it would be provided as soon as possible. This was not till 1913. The first stage of the new administration block had been built and included a Board room (later to become the general office and now the offices of the Superintendent and his staff). This freed the old Board room (now the

splint department) and here and in the vicinity were fitted out rooms for examination, extraction and waiting. Although it was strictly, almost grimly, utilitarian it was at least a Dental Department and Mr Myers, his objective gained, departed with many eulogies from the Board and the staff. Mr J. L. Saunders was appointed (£300) with Miss Wills as assistant (£52). There was in addition an honorary staff of not more than 24 dentists who gave a morning's duty in rotation.

The new department was immediately busy. A second dental chair was procured and in 1914 a model Clark apparatus for continuous gas anaesthesia (£17). At the end of the first year there had been 3329 treatments. The volume of work swelled during the war. The Education Department arranged with the Board for the treatment of children. The Defence Department connived at the treatment of soldiers provided it was free. In 1915 the department moved to the first floor of the administration block with the pathology department as its neighbour.

Among the early volunteers for active service was Mr Saunders. He never returned to the department though in 1920 he was appointed honorary stomatologist to the hospital. He was succeeded by Mr Bell who also enlisted and was followed by Mr Rattray. All these were graduates of the Otago Dental School. Mr Rankin became assistant dental surgeon and a full time dental mechanic was appointed (previously dentures were made by Mr Coulter in private rooms). The cumbersome honorary dental service ground to a stop as the war ended. The sole survivor was Mr Arthur Suckling who for some years thereafter was honorary anaesthetist and dental radiographer. In 1921 he gave 551 anaesthetics. There were no staff troubles after the war. Dental bursars could be directed to employment and by 1924 there were five dental chairs each with a dental surgeon.

In 1927 the department moved again, this time upstairs to the newly erected storey on the administration block, where it still is. It was a welcome shift, for the pathology department badly needed the vacated space. The depression was round the corner. Its first effect was to reduce the work of the department as patients could no longer pay. This was offset at a later

stage by the frank acknowledgment that in most cases no payment could be expected and free treatment was imperative. Even so, many dentists were unemployed during the depression. Some of these were registered with the Unemployment Board which suggested to the Hospital Board that instead of employing such men on roadmaking they would be more useful in making dentures for the unemployed. If the Unemployment Board lent them free to the Hospital Board would the latter supply the material for the dentures? The Hospital Board, which at the moment was staggering under other services it was rendering to the unemployed, demanded ten shillings a set. In those days ten shillings was real money and the Unemployment Board was offended. In the act under which it operated there was nothing about false teeth. Its funds were strictly for the unemployed. Was the Hospital Board unemployed? In the end the unemployed dentists had to give up their plaster and take up their picks. Mr Rattray who was appointed in 1915 resigned in 1919. Mr Paulin became senior dental surgeon for a year and then Mr Rankin, who resigned in 1926 and was succeeded by Mr Ferguson. Dr Reilly (1938-1947) followed. The next appointment was that of Mr A. Russell, the present head of the department.

The work of the department, unlike that of many private dentists, is highly specialised. All epulides and cystic conditions are referred to the department for biopsy, oral sepsis is eliminated from preoperative cases and special apparatus is made for treatments given in the radiotherapy department. From the casualty department and the specialists' outpatients come those with neuralgias, face swellings, infections of the mucous membranes, fractures of the jaws, and those requiring dental X-rays. Not all patients go to the department. For years a dentist had gone round the wards of the hospital, visited the Sanatorium once a fortnight and Burwood once a month. But in 1960 this system was replaced by a full time surgeon based at Princess Margaret hospital who is responsible for all the work in outside institutions including the Chatham Islands. Mr Russell now presides over a department which has eight chairs, seven nurses, six mechanics, five surgeons and one clerk. These are responsible for over 25,000 treatments a year.

The record of the department has been a fine one. It has never been involved in arguments or disputes nor have there been conflicts with any of its staff. It has easily led all other special departments in the fees it has collected relative to the expense involved. It has achieved the paradox of an expansion of its work inside a contracting space, for some years ago it lost 300 square feet of accommodation for the benefit of the nursing school and the medical staff. Despite the fact that it is one of the few departments still to charge fees it has remained popular with patients. (A hundred years ago, Dr Barker, describing his practice, had stated 'I always find it easier to extract a tooth from their head than a fee from their pocket'.) It also has in its staff a tradition of loyalty. In 1959 Miss H. M. Allington retired after being a dental nurse for 38 years. Mr S. F. Craze retired in 1961 from the position of senior dental technician with a total of 39 years of service. In 1954 Miss M. A. McLachlan, who had been in the department for thirty years, resigned her appointment as second assistant dental surgeon.

At present the department maintains ruefully that its integration in the hospital services can be illustrated by the story of one of its patients. She was an elderly eccentric negress who consistently lost each of a series of free dentures. Eventually she was issued with a final warning and a final set. Shortly after, she returned without them. She agreed that she did not qualify for a new set, but had the Department any discarded old ones? She was provided with a piled-up tray of them. She settled down to an afternoon of dental experiment, testing each in turn. Finally she departed with three sets. To the Dental Department this story of something that would function but not comfortably fit is symbolic.

CHAPTER SEVENTEEN

67/29

The Art of Radiology

THE DISTINCTION OF BEING THE FIRST CITY IN NEW ZEALAND to use X-rays was narrowly missed in Christchurch. Roentgen made his discovery in 1895. In 1897 Mr Smith, an electrical engineer of Christchurch, informed the B.M.A. that he was considering importing a Roentgen Ray unit at a cost of £40. At £2 an exposure could he count on the support of the doctors? The B.M.A. wrote back expressing their great satisfaction at the suggestion but regretted that they 'could not give any definite guarantee of employment or fees'. Mr Smith felt that the satisfaction was a little one-sided and did not place the order.

The next year however the staff recognised that an opportunity had been missed. On their behalf Dr Nedwill approached the Board and pointed out that this fascinating new development could be made available for £80. The Board's reaction was surprising for those tough days. Dr Nedwill was instructed to buy it, install it and send the bill to the Board. And when he had done all this he was thanked for his interest in the hospital.

But the new machine was a disappointment. It was housed in a side room of the theatre, dusty and unused, because no one understood its whims. Its only friend was Dr Crooke to whom it was a great joy despite the cynical references of the staff to seeing through a glass darkly. Even Dr Crooke in 1907 admitted to the Board that it was not working properly. The Board called in an 'expert electrician' who earned a fee by reporting that Dr Crooke was wrong and that it was in excellent condition.

Dr Crooke retired in 1909. In 1910 the Board, yielding to the strong persuasions of the staff, appointed Dr M. Inglis as an honorary physician with control of radiology. He was a good man who got the most out of a poor machine. In 1914 he reported that during the year he had taken 444 photos, done 200 screenings and given 848 therapeutic exposures. But he could do nothing about his decrepit apparatus. The Board gave him a couch, a compressor, an extra room and permission to appeal to the public for funds for a new machine. He did not exercise this last option, feeling that he could not make himself heard by the public in the din and clamour of war. He resigned in 1915 and his position was then taken by his recently appointed radiographer, Mr Nelson (£4 per week). Therapeutic exposures now stopped and screenings became rare. The Board made the services available to private cases but the response was poor. In November 1916 Mr Nelson took 116 photos of which 8 were for private patients.

In 1917 the Department, desiring standardisation of equipment, commissioned the radiology expert, Dr Leathem of New Plymouth, to report on the X-ray services in the main hospitals. In Christchurch his report was lengthy, technical and disparaging. Apparently all the apparatus could be divided into one of two categories—the defective and the inoperable. He advocated a completely new plant and better premises. He reminded the Board that though their fee for a plain X-ray was two guineas and for a barium meal three guineas, the standard fee elsewhere was half a guinea. His only praise was for Mr Nelson whom he commended in warm terms for his energy and ability.

The Board, completely intimidated by many pages of incomprehensible technicalities, appealed to the staff as to what should be done. The staff, having obviously got another expert opinion, subjected the Board to a further barrage of technicalities and offered it three choices dependent on the amount of money it was prepared to spend. The Board, which wanted the field narrowed, was not helped by having it expanded, and then consulted a visiting representative of Watson and Son from Sydney. The upshot was that the Board authorised the

expenditure of £350 on new equipment which was delivered in February 1918.

Automatically larger premises were required. When the administration block had been completed the radiology department had allotted to it what is now the house surgeons' sitting room with the dispensary on one side and the physiotherapy on the other. There was much territorial trespass with the physiotherapists being the main offenders. They were therefore moved in 1918 to the old laboratory which had once been the theatre and the radiology department expanded into the vacated premises.

There were also staff changes. Mr Nelson resigned in 1918 because of a severe X-ray burn of his hand. He was replaced by Mr T. Sewell who for the past year had been the hospital's chief electrician. He was to continue as radiological technician until his retirement in 1936. For some time previous to this the Board had been looking for a radiologist so that therapeutic exposures could be reintroduced. In 1919 this position was filled by Dr William Bates who was combining private radiological work with general practice. He was therefore appointed as honorary radiologist. This did not greatly improve matters. Dr Bates was able enough but had very limited time and Mr Sewell still remained the more effective staff member. The opinion steadily grew that a full time radiologist was essential.

In 1921 the right man was found in Dr R. N. Guthrie. He had been a surgeon on the hospital staff before the war, had had a distinguished military career and had taken his discharge in England where, by training and examination, he had qualified as a specialist in radiology. He had brought back his own modern X-ray plant intending to start a private practice in this specialty.

With a radiologist of this calibre looking for work and the Board looking for such a radiologist the matter was simple. The Board did not ask for testimonials for Dr Guthrie carried a name well known and honoured in Canterbury medical circles. His brother John was at the time a surgeon on the staff. Their father, also John, had been house surgeon in 1876. An uncle, Dr T. O. Guthrie, had practised at Lincoln and then at Lyttelton in the eighties where he had been the Board's officer

for charitable aid, the orphanage and the casualty ward. The terms were satisfactorily arranged. Dr Guthrie was to receive £600 a year and half the fees received by the Department with a guaranteed minimum of £1250 a year. The Board was to purchase his equipment at cost. It consisted of about £300 worth of expendable stores and a plant worth £1160. The payments could be spread, interest being charged on the unpaid balance. The Health Department agreed and the appointment was made.

The only person not happy about this was Dr Bates who first learned of the appointment from the Press. He protested to the Board and the B.M.A. He claimed that he had sacrificed other appointments for the sake of this hospital one, that this was for three years and that he was being dismissed after two. He alleged that he had been roughly handled over the whole thing. The B.M.A. agreed and wrote and told the Board so. Several Board members, particularly the Rev. J. K. Archer, were of the same opinion, but beyond considerable discussion not much was done about it. It was generally felt that Dr Guthrie had to come, which meant that Dr Bates had to go, although the manner of his going was definitely lacking in administrative finesse. Dr Bates spent the rest of his career in private practice in Christchurch.

The radiological department now took on a new look. It had a new director, new equipment, new ideas and it got new premises by being moved to the gymnasium which had been erected by the Defence Department in 1918 for the benefit of military patients. Dr Guthrie rapidly established himself as an essential part not only of the hospital services but of the medical services generally. His ability was of a very high order. He had a reputation for irascibility which he rather tended to foster, but it was a very thin mask over a kindly temperament. He was intolerant of insincerity or slapdash work, and house surgeons who had been guilty of a silly diagnosis or a breach of the regulations of the department soon learned the appropriate period of time during which it would be wise to keep out of his way. On the other hand, if he were approached with a genuine problem, he would use every possible resource to help.

Because of the smooth working of the department thereafter

there is little to record in its subsequent history beyond a steady expansion. In 1924 Dr Guthrie went to America to study the latest developments. By this time the radiotherapy department had started and Mr Sewell, assisted by Sister Wiggins, was able to take responsibility again. During the depression the private work decreased though this was balanced by a relative increase in hospital cases. These were the static days which were swept away when free X-rays as a social security benefit coincided with a great increase in knowledge of the radiology of the chest. A random comparison shows that for the month of April 1931 there were a total of 1009 X-rays taken. For the same month in 1937 the figure was 1765. One effect was that in 1934 new equipment costing approximately £1000 was installed. The increase continued despite the war. All recruits and all returned service people were X-rayed. The shortage of films became acute. Dr Guthrie, the Board, the staff and the staff executive all discussed it and the procedure was adopted of taking only essential X-rays. It was probably this restriction which allowed Dr Guthrie to carry on single-handed during the war. He also by now had better facilities as in 1938 a portable X-ray had been purchased (£450) and a dark room established in the theatre block. Despite this, in 1944 he protested strongly to the Board about his conditions of work. He wanted more room and he wanted some assistance. Owing to the war the Board could give him neither. Instead in 1946 it gave him a bonus of 8d for every film he read in appreciation of his heavy burden during the war. It also in due course appointed Dr Jefferson as an assistant, but he left shortly afterwards to join the armed forces in Japan. Dr G. L. Rolleston who had just returned from active service succeeded Dr Jefferson.

Dr Guthrie retired in 1947. He was farewelled at a complimentary dinner by the staff and the eulogies on his work were many and sincere. He had been appointed at a time when the X-ray was a rather insignificant adjunct of hospital practice. He left it a smoothly organised department of high efficiency.

In the days when Dr Guthrie was the sole radiologist the position of radiographer was of great importance. This was very ably filled for 20 years by Sister Winifield. She started

her nurse's training at Christchurch in 1928 and became a ward sister. In 1934 she went to England and qualified as a Member of the Society of Radiographers and was appointed to the X-ray Department in 1935 after the retirement of Sister Wiggins.

Dr Rolleston succeeded Dr Guthrie and the appointment was an appropriate one, even historically. When in 1876 the House Surgeon, Dr J. Guthrie, had inspected the new wards 4 and 5 with the Provincial Superintendent, the Hon. Wm Rolleston, they would have been incredulous if the mysteries of radiology had been explained to them and even more incredulous if they had been informed that between the two wards a large department would be created to exploit this development, the same to be controlled in turn by the son of one and the grandson of the other. Dr Rolleston was a destined radiologist. After he had finished as a house surgeon at Christchurch in 1941 he pursued radiology in Christchurch, London, in various overseas hospitals, and in military hospitals in Egypt and the Pacific, collecting the appropriate diplomas on the way. At Christchurch he was granted the new title of Director of Radiology and as such supervises the plants at Burwood, Princess Margaret, Kaikoura, Akaroa, the Sanatorium and the Chest Clinic.

The growth of the department in the last decade has been enormous. Since 1950 there has been a steady expansion of arteriography, intraosseous venography and retroperitoneal investigation through presacral emphysema. In 1961 functional studies of children with urinary infections were being made and the surgeon was being guided in the delicate task of placing implants in the pituitary body. More would have been done if the ancient problems of staff and accommodation could have been solved. The salary scale set by the Department is not attractive by overseas standards. In 1958 the department was modified and extended so as not only to include part of the old corridor but to sweep out beyond it. Finished with the resources of modern furnishings, the result is spacious and pleasing.

The Radiology department has exerted an important influence on the other members of the hospital staff. It has util-

ised that freak of physics which enables a doctor to look beneath the skin to supply, not a lazy visual approach to diagnosis, but information on which the diagnosis may be based. It stimulates rather than depresses intellectual activity. The radiologists keep themselves well informed on clinical medicine. No clinician can afford to ignore them, and their philosophy of co-operation is such that no clinician would want to.

It is more than likely that some of the younger radiologists who commenced training at Christchurch will ultimately attain eminence. The traditions of history therefore demand a personal reference.

Dr B. M. de Lambert was the first registrar in 1948. He went overseas in 1950, returning the next year to become assistant radiologist. He resigned in 1953 and entered on private practice. In 1949 Dr J. B. Jameson became registrar. He went to England and Scandinavia in 1952, took his D.M.R.D. (England) and returned to the post of assistant radiologist. He assisted Dr de Lambert in controlling the department during Dr Rolleston's visit to America, England and Scandinavia in 1953. Dr B. F. Fazackerly became assistant radiologist in 1958. Other registrars have been Dr C. G. Anderson (1951), Dr H. A. Brant (1953), Dr T. S. Weston (1955), Dr R. J. W. Buick (1956), Dr R. G. Gibson (1957) and Dr C. A. Wiggins (1958).

In 1962 the senior specialists in the department were Drs Rolleston, Jameson and Fazackerly, while the juniors were Drs Weston and Gibson.

CHAPTER EIGHTEEN

627/29

The Science of Radiotherapy

THE RADIOTHERAPY DEPARTMENT DEPENDS ON INTRICATE apparatus, potent chemicals and special skill in their use and its history is therefore primarily the history of its equipment.

Therapeutic use of superficial X-rays was made as early as 1909 in the Christchurch hospital. The results failed to impress either patients or staff. In 1909 Dominici in England was investigating the use of radium. It is therefore surprising that when Dr Fenwick went on active service in 1915 he left his own private supply of radium in the custody of Dr Foster to be used for the benefit of the hospital. It had minor use and minimal benefit, for the staff knew little more than that the stuff was dangerous and the technique was tricky. In fact no radium was being used in New Zealand until after the war except in Dunedin, where Dr P. D. Cameron had employed it constantly since 1911. In 1923 Dr Cameron left Dunedin for Wellington and in that same year all New Zealand suddenly became conscious of radium, and because its limitations were not fully understood, everyone was enthusiastic. The result was a spontaneous movement throughout the country to procure more radium.

The initial movement came from the honorary staff of the Christchurch hospital which advised the Board that Christchurch patients requiring radium were being sent to Dunedin and that it would be advisable for Christchurch to have its own radium and also a deep therapy plant. The Board appointed a sub-committee (Drs Fox, Fenwick, N. Guthrie and MacGibbon) to enquire into the matter. It reported that the idea was sound but that the price was high. The Board agreed with both these

conclusions and considered the cheaper alternative of an emanation radon plant whereby the gas given off by the radium could be compressed in glass capsules. This had similar therapeutic properties to radium but its active life was relatively short. The Board wrote to the hospitals in Dunedin and Wellington, asking what they thought about an emanation plant in either place. Could Canterbury share? Or would they share with Canterbury if a plant were established in Christchurch?

Wellington put the letter in a pigeon hole but talked it over quietly on the Board and with its staff. The staff was strongly in favour of Wellington having its own radium. Then the public got to hear of it. At the time Wellington was running a health campaign and public lectures were given by such well-known speakers as Dr Helen Bakewell, Dr Ada Patterson, Dr Truby King, Dr Platts Mills, Dr E. H. M. Luke, Dr P. F. McEvedy and Dr W. E. Herbert. One of the lecturers was Dr Cameron. He stated that the previous year he had treated 187 cases in Dunedin. He quoted some of his successes. He revealed that he had cured a rodent ulcer by radium eleven years before. (Further reminiscences of these days were given by Dr Cameron in an interview with a Wellington paper in 1959.)

To the people of Wellington this was a civic challenge. The Mayor called a public meeting. Radium was eulogised, a committee was formed and a public campaign was started to raise £10,000. Mr Peter Fraser, M.P., stated in the meeting that the Government would have to give an equal subsidy. The chairman of the Wellington Board (Mr F. Castle) commended the whole project, saying that his Board had been in favour of it ever since a report had been received from the North Canterbury Board.

Auckland, uneasy at these gestures of independence by southern cities, immediately started a public appeal for £10,000. The chairman of the Board (Mr W. Wallace) addressed the Orphans' Club and having declared war on cancer extended the threat to the whole of New Zealand. 'Was Auckland then to take a back seat to Otago or Christchurch in this matter? (Voices: No!) Auckland had taken a back seat too long and should not play second fiddle to any city in the Dominion.'

This threat did not result in much panic in Dunedin where Professor Barnett was advocating radium and where Dr Anderson was shortly to take up office after extensive work in radiotherapy overseas. Dunedin, which always seems to have had a secret technique for gaining its medical objectives without the publicity of a campaign, collected £1000 from its citizens and with £600 Government subsidy, bought some radium and then decided to await the arrival of Dr Anderson and get his opinion on its adequacy.

Christchurch, having started the whole thing, was left isolated, rather like the evangelist who is abandoned by his converts. The Board itself was in favour of a public appeal for £10,000 but the finance committee opposed it. Even the medical committee was not united in its approval of such a costly project. Dr Fenwick was enthusiastic, Dr Fox lukewarm, Dr Guthrie cautious, Dr MacGibbon hostile. It was thought that if the recent bequest of Miss Maude Barrett of £500 (with subsidy) were used enough radium could be purchased for dealing with simple cases. And something might be done by collaborating with the Otago Board. A conference was then held between the two Boards. Dunedin by this time had £5000 of radium and was considering ways and means of raising another £10,000. It was pointed out that Christchurch's little £500 was not of much use to Christchurch but under the terms of the bequest could not be spent elsewhere. Furthermore the whole idea of emanation was steadily losing favour. The decision of the conference was to wait and see what Dr Anderson thought.

In February, 1924, Dr Anderson with all the authority of five years' experience in Europe came to Christchurch. His opinion was a positive one shorn of alternatives. He advised spending the Maude Barrett bequest (now £750) on radium and at the same time installing a deep therapy plant. This would cost £2400 with £600 installing costs. An excellent site was in the recently abandoned old theatre. The Board had placed £4000 on its estimates for this purpose. The time had now come to spend it. The Board concurred and pending the purchase of the equipment considered the matter of staffing the new department. The choice fell on Dr Fenwick. He was offered £300 a year and a third of the fees with a guaranteed

minimum of £650. Dr Fenwick, never loth to explore new fields, agreed.

Then, when the whole scheme had been nicely settled, it was ousted by an alternative. The Board was informed that a philanthropist, strictly anonymous, was prepared to donate £4000 for the purchase of radium. The tag to it was that Dr Fenwick should go to England, train under Professor Lazarus Barlow, chairman of the British Cancer Research Committee, receive a certificate of proficiency from him and bring it back to Christchurch.

This was, in the opinion of the Board, magnificent. The donation and the bequest with subsidy would not be far short of £10,000. All the other centres in the country were campaigning among the public. Christchurch had abandoned publicity for anonymity. At the next meeting of the Board, Dr Fenwick, who was a member, withdrew while the affair was discussed. When he was recalled he was asked if he would go and at his own expense, and would he control the department on his return and would he accept £1000 a year, the same to start from the date he got his certificate? To all this Dr Fenwick replied in the affirmative and caught the next boat.

Any cynical student of hospital history might have commented at this stage that it was all too good to be true, and in this he would have been quite correct. The Government suddenly announced that the subsidy would be halved to ten shillings in the pound. The Board wrote angrily quoting letters from Dr Valentine, Director-General, in which he had stated more than once that an equal subsidy would be paid. The Government was unmoved, it was irritated by these radium subsidy appeals from all quarters, it had discussed the matter at Cabinet level, it was not going to weaken. In the end it refused to write in reply to the Board's protests. It resorted to curt telegrams.

This was serious because the Maude Barrett bequest had been spent and the total sum now available was £6000. But radium cost £17 a milligram or £15 if not less than half a gramme were purchased. Half a gramme would cost £7500. Where was the £1500 to come from?

But this was only the first blow. The second was that less than three months after he left New Zealand Dr Fenwick re-

ceived his certificate which meant that his salary was to start from that date. As he still intended to do considerable study before returning the Board may have thought that the award was a little hastily bestowed, but they could hardly raise the point in the face of the eulogies heaped on Dr Fenwick by Professor Barlow. The latter went on to say that as he was retiring from Middlesex he would have to part with his senior technician, Mr Charles Hines, who was excellent in all ways and who was willing to accompany Dr Fenwick to New Zealand. The Board, added Professor Barlow, should be congratulated on thus getting the services of Mr Hines for whom a commencing salary of £400 would be adequate.

It was a troubled Board that considered these financial obligations. Some were for a public appeal, others were not. In the end the decision was not theirs. Another donor, anonymous except that she was a friend of the chairman, Mr Otley, offered £500 if the public would raise another £500. The Board members became fused in unanimity. At the meeting in which this offer was made it decided to purchase the radium at once, also the deep therapy plant, also to congratulate Dr Fenwick and thank Professor Barlow and appoint Mr Hines. Then, hoping that Auckland would not hear of it, it launched the appeal. The newspapers backed it generously with space and commendation. Within a short time the radium fund, including the £4000 and the £500, but exclusive of subsidy, stood at nearly £6000.

Within six months of leaving, Dr Fenwick was back, full of knowledge and enthusiasm. His confident statement that there was no connection between cancer and smoking was headlined in the press. He had been to hospitals at London, Paris, Stockholm, Copenhagen, Brussels and Manchester. The deep therapy plant had arrived before him as well as 45 mgm of the radium. Dr Fenwick admitted his first cases in November 1924 and within a month had treated 121 with radium and 66 with deep therapy. The tube of this plant (air cooled) was expected to last 100 hours and so only two cases were treated a day. Radium treatments cost a guinea each for hospital patients and two to five guineas for private patients while a course of deep therapy cost from £10 to £25.

The Board decided to order a new water cooled Coolidge tube at a cost of £575. Within the first six months the original tube broke down. Dr Cameron lent a second-hand one and the new one arrived. So did the rest of the radium and Mr Hines. Dr Fenwick took the radium as necessary to Ashburton, Timaru and Greymouth. At the end of the first year the department possessed 458 mgm of radium in 97 needles, 7 plaques and 15 tubes. There had been 3831 attendances and radium had been used 1614 times and 491 treatments by deep therapy had been given. An endothermy machine had been purchased. Dr Fenwick reported that all the new equipment was giving satisfactory results. Dr Fox who was always more responsive to human achievements than to scientific marvels measured the results with a different yardstick. '... when one views the pathetic spectacles of those suffering from advanced malignant disease one is consoled with the knowledge that where science has failed at least these poor sufferers are cheered by the unbounded benevolence, kindness and goodness of heart that is offered to them by the officer in charge. None go away uncomforted.' Dr Fenwick was not intimidated by this. In 1925 he salvaged a case from the theatre and applied deep therapy through an open abdominal wound. In 1926 an ultra violet light plant was purchased for the department (as well as one for the sanatorium).

The water cooled tube expired in 1929 after a record life of three and a half years. A new one was on hand and was immediately installed. In the same year some radium was sent to England to be transferred from steel needles to platinum ones. It was expected that there would be an inevitable loss and in order to make this good and to pay for the alteration an application was made to the Travis Bequest trustees for £500. The trustees granted £350, with which another 21 mgms was purchased. Of the 115 mgs sent 112 mgms came back—a result which exceeded all expectations.

As with so many other departments there was no expansion during the years of the depression. In fact, only the clause that no fees would be claimed from those who couldn't pay allowed it to function at its normal pressure. Dr Fenwick meticulously reported on the work done and added a good deal of philoso-

phy about cancer. (His annual report to the Board in 1928 covered 22 pages.) Patients came and went, Dr Fenwick gave a paper to the radiological section of the B.M.A. conference at Mt Cook, some radium was loaned to Timaru (where some of it was lost), Mr Hines devised an ingenious frame for sterilisation and Coolidge tubes added to the worries of the department and the expenses of the Board. In 1933 the Stockholm treatment of carcinoma of the breast (irradiation before and after surgery) was introduced.

By 1936 the defects of the deep therapy plant were very obvious and a completely new plant was installed by Watson and Son. The Canterbury and Westland branch of the Empire Cancer Society gave £1750 and the Board raised £2000 by levy. There was no Government subsidy. The old plant had given a total of 19,000 treatments.

In 1934 the Consultation Clinic was formed and the surgeon and radiotherapist no longer had to dispute for cases. In the clinic radiotherapists, dermatologists, plastic surgeons and at times pathologists conferred on the cases submitted and a plan of treatment was formulated after general consultation.

Radiotherapy, like all forms of therapy, has its dangers and all those who practice it live in fear of the effects of the overdose. After nearly twenty years of successfully avoiding these hazards the department in the early forties had two unfortunate cases of burns alleged to be due to overdosages. These cost the Board £6500 in damages.

In 1943 Dr Fenwick retired. He had exceeded the normal age limit and had it not been for the war would have retired sooner. He had been appointed to the staff forty eight years before and in that time had associated himself with almost every progressive enterprise in hospital activities. He retired to Sumner and died in 1958.

For two years thereafter, Mr Hines, clinical assistant and senior radiotherapy technician in New Zealand, was in charge. The Board, a little uneasy after the recent litigation, decreed that no soft X-ray treatment was to be given unless first authorised by a qualified medical man, and the State Fire Insurance introduced the same proviso into its policy. The staff

executive passed a vote of complete confidence in Mr Hines. This was justified as there were no more claims.

In April 1946 Dr A. J. Campbell was appointed head of the department. He had graduated in Melbourne ten years before and had later taken his diploma in diagnostic and therapeutic radiology. With Dr Campbell came new techniques. Nitrogen mustard was first introduced in 1947 and since then T.E.M., leukeran, colechidine, nitrofurazone, 6-mercapto purine, R48 and methane, myeleran, and hormonal treatments. The first of the isotopes was radioactive iodine in 1948. Since then radioactive phosphorus, gold chromium, cobalt and iron have all been used. An isotope laboratory was opened in the basement under ward 12. In 1960, 49% of the radio isotopes imported to New Zealand were used by the Christchurch hospital.

Inevitably larger premises were required. The old theatre began to extend and in 1948 extra accommodation was found for skin treatment units and two additional deep therapy units with a new opening on the side corridor. In 1953 Dr Campbell went to America and Europe. Dr Goldstein had been appointed as assistant radiotherapist a few months before and controlled the department in Dr Campbell's absence.

Dr Campbell's visit was not entirely to study techniques. When in London an interview was arranged through the High Commissioner's office between Sir Arthur Sims and Dr Campbell. Sir Arthur, who had first shown his interest in the Christchurch hospital by donating £1000 in 1918 in honour of his mother, and his wide interest in medicine generally by later founding the Sims professorship, had become interested in the Cobalt 60 unit which the Canadian Government had just presented to the United Kingdom. He now announced that he was desirous of presenting £30,000 for the purchase of a comparable machine for New Zealand, preferably to be installed in Christchurch.

It was easy for Dr Campbell to assure Sir Arthur of the value of such a unit and of the gratitude with which the gift would be received. It was more difficult to decide the type. Various opinions were taken, including that of Sir Stanford Cade who was operating the one of Canadian origin. The final decision was in favour of the theratron moving field unit which was

accordingly ordered and which arrived in November 1956. Though damaged in unloading, it was repaired, installed and the first patient was treated on February 28, 1957.

The unit required departmental changes. To house it the premises had to be greatly enlarged with a separate entrance from the main corridor. Opportunity was taken during the building to provide for diagnostic X-ray and dark room facilities, mould room and a Resomax deep therapy unit.

In preparation for the new supervoltage unit, Dr Goldstein and the chief physicist, Mr Borthwick (appointed 1954), visited Canada and the United Kingdom in 1956 to gain experience in this type of therapy.

Just as the initial demand for radium in Christchurch alerted interest in other parts of New Zealand, so has the theratron, and supervoltage units are now installed or about to be installed in Auckland, Dunedin, Wellington and Palmerston North. In the meanwhile the Christchurch one is treating an average of thirty cases a day.

Within the last few years there have been innumerable improvements and extensions of treatment. They are too technical to detail except to record that the McWhirter treatment of mammary carcinoma was used intermittently till 1954 and thereafter almost exclusively. The Manchester routine for therapy of carcinoma of the cervix is used and by the end of 1958 the Sheffield technique (Blomfield) had been adopted.

Compared with pre-war days the department is now in every sense new, even to its staff which now numbers fourteen. Miss M. Fox, daughter of Dr Fox, retired in 1948 after twenty three years as a technician. In 1955 Mr Hines, with thirty years of loyal service behind him, also departed along with Miss Page, who had been a technician for twenty years and, during the war, a voluntary overtime worker in the laboratory. The joint retirement of these two popular members was not as accidental as it seemed for to a very select few it was known that they had married. Still fewer knew that they had been married for ten years.

In review it will be seen that the present department began to shape to its present form from the time when the donation of £4000 was made as a result of which Dr Fenwick went to

England. The gift was strictly anonymous and officially has remained so since. But the donor, Sir Arthur Sims, has for the purpose of this book, consented to reveal his identity. It is a significant disclosure for it fits to a pattern of philanthropy dedicated to the welfare of the sick. It is against the background of Sir Arthur's interest in the radiotherapy department in Christchurch, spanning the interval between the early radium and the later theratron, that his other magnificent contributions to the medicine of the Commonwealth have been made.

CHAPTER NINETEEN

627/29

The Story of Anaesthesia

THE MEDICAL SUPPLIES FOR THE NEW COLONY IN 1850 WERE carried on the *Charlotte Jane* and among them was chloroform. This remained the anaesthetic of choice for many years though the doctors were well aware of its dangers. Towards the end of the century the matter of anaesthesia was often discussed at B.M.A. meetings and the advocates of ether steadily grew. In 1889 Dr Jas Irving stated that in 30 years of practice he had used pure chloroform exclusively and had had no deaths. In 1892 the advantages of nitrous oxide were stressed and the comment was made that the apparatus could be purchased for £9. In 1895 a cocaine spray was demonstrated. Spinal anaesthetics were first used early in this century.

Sixty years ago there was little incentive for research into anaesthesia. The hospital averaged one or two operations a day. Most of the minor work (and all the surgery performed by the dresser, Brown) was done without an anaesthetic. Up to the twenties some anaesthetics were given by the honorary dental anaesthetist, Mr A. Suckling. The rest were administered by the house surgeon and were usually a mixture of chloroform and ether in what were regarded as the most suitable proportions to avoid the dangers of the former and the discomfort of the latter. This was given from a drop bottle on an open mask and the modern anaesthetist refers to his predecessors of these days as the rag and bottle boys.

Just after the first war it became difficult to find anaesthetists to cope with the increasing volume of surgery. The second theatre was opened in 1922 and the Board advertised for another house surgeon but got no replies. It then tried to get an

honorary anaesthetist. This too failed until 1926 when Dr Hazel Allison agreed to serve. She was joined the next year by Dr E. Hayes who retired in 1929 because of ill health. His place was taken by Dr E. H. H. Taylor, later to become Director of the Department of Anaesthesia. The honorary position was abolished in 1937. Dr Allison received £250 a year and her five assistants £150 each.

All attempts at orderly staffing broke down during the second war. One of the first to go on active service was Dr Taylor and one by one the others followed. The Staff Executive dealt almost monthly with the problem of supplying anaesthetists. Usually they were to be found among the general practitioners of the city, most of whom were cramming so much work into the day that a little more did not seem to matter. When at any session attendance was impossible the duties were taken up by the house surgeon.

Stable and dependable all through the war was Dr Allison despite her private work and responsibilities of family life. In 1944 she intimated that she wished to retire. Dr Taylor had returned but was still in the army. The Staff Executive successfully pressed for his release. He was demobilised and returned as part-time Director of Anaesthesia. He was given nine part-time anaesthetists working on two sessions each. A registrar was approved but could not be found until Dr Saunders was appointed in 1952. In 1954 the Anaesthetic Department was formed and two years later Dr Taylor, able and urbane, became its first Director with senior specialist status. In the same year Dr Greatrex became his assistant. He had had lengthy experience in England, especially in plastic surgery, and consequently most of his work is done at Burwood.

The department now has a staff of four full-time anaesthetists—(Dr Taylor, Dr Greatrex, Dr D. C. T. Bush, Dr R. Thompson) and in 1961 eight part time visiting anaesthetists (Dr P. M. Tripp, Dr J. M. Louisson, Dr M. S. Smith, Dr W. J. Pryor, Dr W. B. Barlow, Dr E. V. Osmond, Dr S. C. Peddie and Dr C. J. J. Morkane). The whole staff forms a pool from which the three main hospitals are supplied.

The modern era in anaesthetics began in 1924 when Dr Fox

persuaded the Board to purchase a gas oxygen ether apparatus. Then came the new anaesthetics. The first was avertin, administered rectally, satisfactory for induction but later abandoned because of possible hypotension and liver damage. There followed the intravenous anaesthetics—evipan, followed by the much more satisfactory pentothal. In 1937 the Board purchased cyclopropane with an appropriate attachment for the gas machine. The next improvement was the use of curare as a muscle relaxant. In 1957 fluothane was first used.

This wider choice gave scope for wider skill and its perfection established a new specialty. The surgeon began looking not for a man who might give a good anaesthetic but for an anaesthetist. The surgeon and the anaesthetist are now a team and as the surgeon has developed the new techniques the anaesthetist has kept in step. Unlike his counterpart of the past he now has to have a deep knowledge of the physiology of respiration and circulation, of tracheotomy, of intravenous therapy and of resuscitation. In Christchurch since 1957 he has had a new six bed recovery block and only since then has it been realised how great were the old hazards of the anaesthetised patient in the ward. Deaths due to anaesthetics now practically never occur unless the patient has been in extremis and the surgeon has lost in the gamble. At the time of writing the last four such deaths spanned a series of over 9000 anaesthetics.

This moulding of a delicate specialty from the coarse clay of general practice in a period of twenty years is one of the most significant items in the modern progress of medicine. A development is never as dramatic as a discovery but it can be as important. The new anaesthetist has not only opened up a future but he has buried a past. He no longer is a member of a class which at times has included nurses and hospital dressers. He is not now expected to supply his anaesthetic and some hours of his time for two guineas a case. He has ceased to plead for a recognition by the Department of a just salary scale. He has left behind the day when a country practitioner would regard himself as anaesthetically adequate if he had a bottle of chloroform, a piece of wire and a pocket handkerchief.

As in all true medical progress the greatest benefit lies with

the patient. The fear of induction and the misery of recovery has gone. The vomitus is not inhaled, the surgical shock is rare, the wound does not yield, the ventral hernia is absent and the surgeon can keep both eyes on the operative field. Like birth, anaesthesia is now but a sleep and a forgetting.

CHAPTER TWENTY

CH/20

The Arrival of the Specialist

THE GROWTH OF SPECIALISM IN THE HOSPITAL WAS, LIKE ALL growth, almost imperceptible. Specialism is based on a profundity of knowledge which a genius can rapidly acquire and the lessons of experience which can be learned only through the slow passage of years. The story then of its first development from the matrix of general practice is the story of its authors and their immediate predecessors. References to individuals therefore become unavoidable. Such references are restricted to the essentials of hospital history only and biography is avoided.

Among the physicians the main leader in the interval between the mediaevalism of the twenties and the renaissance of the thirties was Dr Hand Newton. Appointed in 1919 he survived all his contemporaries and many of those who followed. His sincerity and integrity made him a worthy senior physician but he was, in addition, sensitive to the importance of change in the rapid expansion of medicine. He was born in one tradition but acquired another. Like Dr Fox he was a champion of the rights of the younger men. It was under his wise guidance that hospital work became zoned, that specialties arose and the present shape of hospital practice became defined. His knowledge of medicine and its application was broad and practical and has been preserved in *The Christchurch Hospital Medical Manual* of which he is the author. Its primary purpose is a guide to the diagnostic procedures and the therapeutic scope of the hospital but it also serves as a convenient index of medicine. The first edition appeared in July 1945, the fourth in 1955. The book is widely used. All the royalties from the

book were given by the author to the Canterbury Medical Library.

Dr Hand Newton's main predecessors or near contemporaries (with the dates of their first appointments) were: Dr Duncan (1906), Dr Lester (1909), Dr T. Will (1906), Dr G. Russell (1910), Dr Crooke (1913), Dr J. C. Pairman (1916). In 1923 there were three notable appointments—Dr Wm Irving, son of the famous Dr Jas. Irving, whose home later became the Limes hospital, Dr John Marks who, contrary to a common belief, was not related to Mr Hyman Marks, and Dr F. V. Bevan Brown whose brilliant promise was cut short by an early death.

Prominent among the early surgeons of this century were Dr P. C. Fenwick (1902), Dr H. T. D. Acland (1904), Dr A. C. Sandston (1905), Dr T. A. MacGibbon (1912), Dr C. L. Nedwill (1912), Dr A. J. Orchard (1915), Dr H. L. Widdowson (1920), Dr E. D. Pullon (1923), Dr N. S. Whitton (1923). The most famous of these from the point of view of a hospital career was Dr Acland. He had wise surgical judgment, was a master of operative technique, and having raised the standard of surgery maintained it for many years. His influence was all the greater because of his personality. As chairman of the staff he was invited to attend meetings of the hospital committee and this custom still persists. He had a marked effect on hospital policy even before he became a Board member. He was a veteran of the Boer war and both world wars. He resigned in 1929, was knighted in 1933 and died in 1957.

The tradition of expert surgery as established by Sir Hugh Acland was ably carried on by Mr P. S. Foster who began his long hospital career in 1910. Many house surgeons who first encountered him as an external examiner in anatomy learned much later by studying his skilful methods in the theatre. He was first elected to the Hospital Board in 1927. He resigned in 1938 when the staff ceased to be honorary but was re-elected in 1947. On his retirement from the staff he was Director of Surgical Services.

Another surgeon with a worthy record was Dr John Guthrie, appointed in 1915, forty years after the first appointment of his father. His brother Neil was radiologist. An uncle was

Dr T. O. Guthrie of Lyttelton. Dr John Guthrie became well known for his surgical treatment of thyroid disease. He died in 1941.

When, after the first war the building programme slowed down, the momentum of change continued but was now transferred to the honorary staff. Casual retirements and replacements are of course common to the staff of all hospitals but in Christchurch the changes, casual as they were, yet in retrospect would almost appear to be the result of a planned procedure. In 1910 the staff was a heterogeneous collection of capable men who had trained in various parts of the world and were isolated professionally in the individualism of private practice. By 1930 the staff was increasing with a number of younger men most of whom had graduated at Otago and had then studied overseas. Their major contribution was that they established and defined certain clinical specialties. They also shattered the tradition of their predecessors that though some doctors might be better than others such information must at all costs be kept from the public. The effect of so firing the flame of ethics with the fuel of mediocrity was illustrated in 1901 when Dr Graham Campbell retired from the position of assistant house surgeon and offered his services on an honorary basis as officer in charge of a gynaecological outpatients clinic. The Board approved, allotted him Wednesday afternoons, provided two couches and some nursing staff and stipulated that all surgery on such patients had still to be done by the honorary staff. But at the next meeting a letter of protest from the staff led to the appointment being rescinded. The following month Dr Campbell was appointed to the honorary staff and abandoned his attempt to form a special department. In 1905 Dr Hammersley offered his services as gynaecologist. On the advice of the staff the Board rejected him. He applied again the next year with the same result. In 1908 the Board asked the staff whether, as a general policy, a gynaecologist was advisable. The staff said no. The hospital is now staffed entirely by specialists many of them restricting their work to special departments. Such departments can never be created by emphasising a policy nor lifted from the ruck of general medicine and surgery by merely appointing a man to their control. The

man is more important than the title. In the present instances the Board did not create a specialty and appoint a man. Rather it appointed a man who, by ability and energy, defined a specialty.

The first of these in time was the Ear Nose and Throat department. In 1896 the honorary staff had asked the Board to establish an ENT department. The Board replied by asking Dr Manning, the ophthalmic surgeon, to include ENT cases in his work. This practice, which was not favoured either by the staff or later Boards, persisted until 1912 when Dr T. A. MacGibbon was appointed as aural surgeon, being the first in Christchurch to limit such work by excluding ophthalmology. He was assisted for a time by Dr Stevenson. In 1921 Dr T. Mill, who had first come on the staff as a physician in 1906, became an assistant aural surgeon. In 1923 Dr N. S. Whitton was also appointed but died of endocarditis shortly afterwards.

Dr MacGibbon was a vigorous personality who had graduated in arts at Otago and in medicine in Edinburgh. After a period on active service he was reappointed in 1920. In 1923 he first used the bronchoscope in hospital. It was his own instrument, purchased in America and the Board reciprocated by allowing him to admit his private cases to hospital and charge a fee. Like all pioneers of difficult techniques he had his failures and in 1924 the Board paid the expenses of a young man who had inhaled a shirt button to go to Chevalier Jackson in America.

Dr MacGibbon was widely read in all aspects of medicine but his main work was in laying a solid foundation for the ENT department. He resigned in 1933 and Dr Malcolm Robertson succeeded, remaining till 1958. During this time the scope of the work was steadily enlarged and new techniques incorporated. For most of this period Dr W. G. Scannell also worked in the department. The department is now firmly established and the main credit for this goes to Dr MacGibbon and Dr Robertson. It is at present controlled by Mr Ross Smith and Dr T. P. Cannon.

The specialty of ophthalmology has always been recognised in the hospital from the time of the first superintendent Dr Stedman and was maintained in unbroken continuity until 1920 when there were no applicants. The Board advertised

throughout New Zealand and the Department of Health investigated overseas. Finally Dr H. Wales was induced to come from Auckland with a promise of his private practice being subsidised if necessary to make it £1000 a year. He established a very large ophthalmic outpatients. He retired in 1946. During the difficult war years he was ably assisted by Dr Caroline Stenhouse whose very valuable services continued till her retirement in 1960. The department has now greatly increased in size. At present the senior ophthalmologists are Dr W. L. B. Burns and Dr H. J. Wales (jnr.) assisted by Dr A. C. Sandston and Dr R. D. Suckling.

Dr Edgar Reay was appointed as house surgeon in 1923 and assistant surgeon in 1930. It was soon evident that his main interest was in genito-urinary work and it was equally evident that in this field he possessed outstanding ability. By meticulous attention to detail, especially in the pre and post operative phases, he began to reduce, almost spectacularly, the previous great hazards of this work. Much of his work has been original and has been recognised as such overseas. He has on two occasions in America been guest speaker at urological conferences. Previous to his appointment genito-urinary work fell to the lot of the general surgeon. That era has now long passed. When he retired in 1959 the department was taken over by his two assistants Mr N. F. Greenslade and Mr W. L. F. Utley.

Neurology, so long despised by many doctors because of difficulty of diagnosis and paucity of therapy (both incorrect assumptions by those who lack special neurological training) began to achieve a new dignity in 1926 when Dr R. H. Quentin Baxter was appointed to the staff. Though a general physician he had had special training and special interest and special ability in neurology. By the generous time he has given to consultation and teaching and also by the influence of his personality he has spread a new interest in the subject among his colleagues. He was Director of Medical Services following Dr Hand Newton. It was his initial work in neurology which made effective the participation of North Canterbury in the neuro-surgical unit in Dunedin. He was the first to hold the

title of Hospital Neurologist and when he retired in 1956 Dr Graham Riley, equally competent, succeeded.

Cardiology was a special interest of Dr J. S. Whitton who was appointed in 1924. He was a physician who had an electrocardiograph which the Board bought in the same year on the recommendation of the honorary staff. It was not a very good investment. The machine was cumbersome and the earth tremors when the No. 8 tram was passing added hazards to the record. There was no technician and there was little knowledge of nor interest in the subject. Despite the optimism of the Board in fixing a fee of five guineas for each electrocardiogram the machine was rarely used until Dr Malcolm Gray became assistant physician in 1926. He, the first true cardiologist in Christchurch, had studied under Sir James McKenzie and he regarded the electrocardiograph as an essential item of equipment. At his request a concrete base was erected to which the machine was bolted. During the depression the Board attempted to discontinue the service but Dr Gray resisted this. He developed the tracings himself and worked without a technician until Mr Harris was appointed in 1930. Ever since he joined the staff Dr Gray has been prominent in cardiological practice, teaching and research. He was a pioneer in the use of anticoagulants and hypotensives. On his retirement in 1958 he was Subdean of the Faculty and Director of Medical Services. Dr A. W. S. Ritchie, who for some years had been established in private practice as a cardiologist, was appointed to the vacancy.

Orthopaedics was part of the sphere of the general surgeon until thirty years ago. It was rescued from this and consolidated into a special department by Mr J. Leslie Will. The details of this rapid and secure development are given elsewhere. Mr Will retired in 1956 and handed over to Mr Rex Blunden and Mr A. B. Mackenzie with Mr W. A. Liddell as an assistant.

The development of pediatrics is linked with the name of Dr J. F. Landreth who has associated himself with so many progressive enterprises in the hospital and elsewhere in the medical world, including the presidency of the New Zealand branch of the B.M.A. (1959). Of all the many physicians who

have worked at times in ward 9 he alone has survived to become the head of a new department to which only trained pediatricians are now admitted. As superintendent of Karitane hospital he has been able to make effective transfers between the two institutions. He has at times commanded loyal support. One example was Sister Holderness, who for many years was in charge of ward 9 and who acquired a vast knowledge of the physical and psychological frailties of children. Another was the first assistant pediatrician, the late Dr Stewart Hunter, distinguished in academic attainments, military achievement and personal worth, and who died in 1957 at the height of his career. Dr F. T. Shannon was appointed to the vacancy.

The obstetrical and gynaecological department differed from some other departments in that it had a prolonged labour with changing midwives. Except for a short period about 1880 there was no gynaecologist till Dr Jellett was appointed in 1920. He was followed two years later by Dr Lindsay, then Dr Jessie Scott and Dr Leslie Averill, the last two resigning in 1936. None of these had the long contact which is necessary before that steady pattern of practice can be produced which is the framework of a special department. Despite this, Dr Averill as senior obstetrician and prominent gynaecologist in Christchurch for many years, has had a deep influence on the profession not only in Canterbury but throughout New Zealand. He is a past president both of the New Zealand branch of the British Medical Association and of the New Zealand Obstetrical and Gynaecological Society, chairman of the Committee of Management of St George's Hospital, superintendent of St Helen's Hospital and is the present chairman of the Hospital Board. In 1936 Dr Mark Brown was appointed with Mr Macmillan as assistant. During his twenty year term of office Dr Mark Brown travelled extensively studying particularly the most modern methods of treating pelvic malignancy. His work has always been characterised by thoroughness and when he retired in 1956 he left a firmly established department, modern and efficient by world standards. He had been ably supported by Mr Macmillan who replaced Dr Mark Brown when the latter went on active service and when he retired in 1956. Mr Macmillan, in addition to his gynaecology,

is a present Board member and is continuing the family tradition of representation on the Board which began with his grandfather in 1887. His contribution to this present history has been acknowledged in the preface. When he retired in 1958 the department was reorganised. Mr G. I. Louisson, who had been an assistant for some years, became a senior as also did Dr A. M. Hartnell who for many years had been the Board's obstetrician, working partly in the hospital but mainly at the Essex Home. The two assistants in the department are now Mr A. H. Foate and Dr K. Drayton.

Dermatology had always been regarded as one of the more tedious derivatives of general medicine until Dr P. Allison was appointed in 1925. He soon demonstrated that the subject involved far more than a selection of the appropriate application for the skin. Dr Allison was a surgeon who because of ill-health had to change his specialty. He chose well and it was not long before all members of the staff were glad to get his opinion on difficult cases. The dermatologists at present are Dr A. D. Muir and Dr D. A. Larnder. They have few beds but a very large outpatients' clinic.

The gastroscope was first introduced to Canterbury in the late thirties by Dr Eric McPhail of Rangiora who secured a hospital appointment for regular sessions. He resigned when war service involved him in naval duties and he subsequently made the navy his career. The present gastroscopist is Dr T. R. Anderson.

The hospital, through no fault of its staff, did not have a department of psychiatric medicine till 1960. The staff of Sunnyside hospital conducts a clinic at St Andrew's outpatients but there is no psychiatric ward in the hospital. Until a ward is available such patients have to be accommodated in general wards or occasional single rooms. By general approval of the staff most psychiatric patients have been for years referred to Dr Melville Aiken. Initially a general physician, he showed his special ability in psychiatry while overseas on active service, has given increasing evidence of it ever since, and is now a part time officer of the Mental Hygiene Division. Though the new department was formed a few months after his resignation, Dr Aiken must be regarded as one of its main architects. In

1961 the first full time psychiatrist was appointed in the person of Dr J. R. Dobson.

The specialty of diseases of the chest was first introduced by Dr Wm. Aitken. After Dr Aitken's premature retirement in 1948 due to ill health, Dr Landreth associated himself with this work. Since then it has expanded until now a special chest committee meets weekly to consider the difficult cases. This committee is an excellent example of co-ordinated team work. It comprises physicians, chest surgeons, radiologists and representatives of the sanatorium and Health Department. A new appointment in 1958 was that of Dr W. J. S. Smith with an already established reputation as a chest physician. He followed the retirement of a general physician, Dr F. O. Bennett. Endocrinology at present is the special sphere of Dr H. R. Donald, infectious diseases of Dr J. A. K. Cunningham and rheumatology of Dr C. Gresson. Dr D. R. Hay was appointed in 1959 and Dr E. E. Hannah in 1960. Another prominent physician was Dr R. C. S. Dick who resigned in 1959 to become the first Medical Superintendent of Princess Margaret hospital.

In the last twenty-five years there have been big advances in both the scope of surgery and the pre and post operative care. Prominent in this progress has been Mr L. A. Bennett who became Director of Surgical Services on the retirement of Mr Foster. In addition to the surgical efficiency which he both practised and preached, Mr Bennett has had an important influence on hospital policy. For a long period he was a very prominent member of the building committee. He is also remembered for the fact that before his departure on active service he organised an elaborate and efficient scheme for emergency medical services. For many years he has been chairman of the Canterbury and Westland branch of the Empire Cancer Campaign and is now New Zealand president. Many innovations in the surgical practice of the hospital were initiated by him. He retired from the staff in 1957 and was elected to the Board in 1959.

Equally prominent in surgical judgment and technique was Mr W. M. Cotter who was on the staff from 1933 till 1957. His special interest, apart from surgery, was medical education and he was active in the early progress of the Canterbury Medical

Library and the Post-Graduate Committee. Like Mr Bennett he has been energetic in the cancer campaign and for years was chairman of the consultation clinic.

In the post war era there have been four able senior surgeons all with long service—Mr J. K. Davidson, Director of Surgical Services (1957-1960) and a fearless protagonist of a just cause, Mr W. H. Bremner, the present Director, to whom a difficult problem is always a challenge, Mr D. McK. Dickson, versatile in ability and independent in judgment and Mr D. G. Radcliffe, highly qualified in both medicine and surgery, who retired in 1959. More recently appointed surgeons, already continuing the tradition of their predecessors, are Mr I. D. Gebbie, Mr H. E. H. Denham, Mr J. W. Ardagh, and Mr P. Cotter. The present (April 1962) assistant surgeons are Mr T. Hurrell, Mr G. W. Holland, Mr E. G. Perry, Mr J. M. Bremner and Mr W. O. S. Phillipps.

Of the surgical specialties reference has already been made to orthopaedics, genito-urinary surgery, ophthalmic and ear, nose and throat work. Chest surgery was first initiated by Mr Bennett and to some extent by Mr Cotter. It developed more when Mr Denham, with an impressive record in this work, was appointed in 1953. It expanded even more when Mr Heath Thompson became chest surgeon in 1954. Mr Thompson is a full time surgeon on the staff.

The first outpatient specialty was the venereal disease clinic. Up till the beginning of this century such cases could not be treated either in or out of hospital. A house surgeon could be dismissed (and was) for admitting a venereal disease patient to hospital. But in 1897 Dr Fox openly broke this rule. The Board called on him to give his reasons. This he did vigorously. The Board agreed that as it was his first offence the matter would be overlooked. Knowing the fighting qualities of Dr Fox the Board quietly decided to overlook the second and subsequent admissions. Thereafter the very sick patients were treated in hospital but there was no special clinic for the less serious ones.

Such a clinic was first proposed by Dr Fenwick in 1914. The Board immediately agreed and appointed Dr Hand Newton as the officer in charge. Almost immediately, presumably for quite

different reasons, he went on active service. During the war the clinic was controlled by Dr Sandston who was replaced in 1919 by Dr A. C. Thomson who continued until his retirement in 1953. This long period of service, in most of which Dr Thomson was most ably assisted by his technician Mr C. Read, was an outstanding one for it not only covered the years when this plague was at its height (in 1930 there were 500 new patients and as many as 100 attending at one clinic) but it was marked throughout by the constant courtesy, efficiency and patience of the medical officer in charge. Dr Thomson was succeeded by Dr W. M. Platts.

These references to staff are deliberately expressed in broad terms as it would be invidious to deal in detail with one's contemporaries. The main motive for abandoning the original intention of making no personal references in the last two decades is the obligation of historical accuracy. In the remote future when the history of the hospital can be reviewed with complete objectivity it will probably be agreed that the last twenty five years have been the most progressive in the last hundred. It is not the expansion of the old tradition which is so notable as the creation of the new. Even though other hospitals have advanced comparably it has always been due to the right men in the right place at the right time. If the merits of the present and recent hospital staff as a whole are to be acknowledged in the future they should at least be recognised now.

The present staff has a loyalty to the hospital and a continuing loyalty is the basis of a tradition. This needs no further elaboration than the comment that in the last few years Dr Averill, Dr Allison, Mr Brownlie, Mr Davidson, Mr Bremner, Mr Radcliffe, Mr Robertson and Dr Donald have seen their sons appointed as house surgeons or registrars at the Christchurch hospital.

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Education in the Hospital

THE UTILISATION OF THE HOSPITAL AS A CENTRE FOR MEDICAL education began in 1902 when the staff used to meet every Sunday morning for the discussion of clinical problems. This practice in various forms has persisted since through the Clinical Society (1930-1952) which was founded by Dr F. V. Bevan Brown and which was based on the hospital though sponsored by the B.M.A., through the Saturday morning clinics for general practitioners (approx. 1949-1952) up to the present clinical meetings and the clinico-pathological conferences alternating weekly.

For many years the enterprising medical student has been made welcome in hospital. The first official recognition of his status was in 1926 when a small group spent their last year in the hospital and so covered the difficult transition period between the five and six year courses. This was not repeated till 1937 when the Branch Medical Faculty was formed with Dr A. Nelson as the first Subdean, followed for many years by Dr M. Gray who in 1958 was succeeded by Dr J. F. Landreth. Since 1937 approximately twenty final year medical students have been allocated to the hospital and their training entrusted to the staff along the lines laid down by the Branch Faculty. In 1960 the first full time teaching and research unit with Dr D. W. Beaven, late senior medical registrar, in charge began working in the Princess Margaret hospital. In the same year the Canterbury Medical Research Foundation was launched at a public meeting held in the nurses' recreation hall.

The first postgraduate course was held in 1938. Its main advocates were Mr Dickson and Mr Cotter. It and some subse-

quent ones were of local production, all the programme being filled by members of the hospital staff. They were good courses and were well attended by representatives from all over New Zealand but obviously required new blood to maintain a satisfactorily high standard. The various eminent men who have supplied this stimulus have been:

1950 and 1957	Dr Williams (Director Clinical Services, Melbourne)
1952	Prof. Charles Rob (St Mary's Hospital, London)
1953	Prof. J. McMichael (Postgraduate Medical School of London)
	Sir Heneage Ogilvie (Guy's Hospital)
1954	Dr R. Orton (Director of Anaesthesia, Prince Alfred Hospital, Melbourne)
1954	Dr J. G. Scadding (Brompton Hospital, London)
	Prof. R. Milnes Walker (Bristol University)
1955	Sir Robert Platt (Manchester University)
1956	Dr J. M. Sheldon (Wolverhampton)
1957	Prof. Maurice Ewing (Melbourne University)
1958	Prof. Eric Nansen (University of Saskatchewan)
	Prof. R. R. M. Lovell (Melbourne University)
	Prof. C. R. B. Blackburn (Sydney University)
1959	Prof. C. F. Davidson (Harvard University)
1960	Prof. R. P. Jepson (Adelaide)
1961	Dr Paul Wood (London)
1962	Prof. G. W. Taylor (St Bartholomew's Hospital, London)

The heavy expenses of such courses are met by members of the Branch Faculty allocating their teaching fees for this purpose supplemented by the fees paid by those who attend. In these days of brief air travel the hospital frequently welcomes famous passing men. In the last few years lecturers at the hospital have included the late Sir Harold Gillies, Prof. Derek Denny-Brown, Dr Paul Wood, Prof. Eric Nansen and Dr C. J.

C. Britton, all of whom are New Zealanders, the last three being ex-members of the Christchurch hospital staff.

Postgraduate education involves statistical review and this is dependent on good case records. These were not even attempted until 1904 and then only after the staff and the Hospital Committee had insisted. Thereafter they were reluctantly done by a resident staff of two and without any one to control them or anywhere to store them went on increasing in bulk and decreasing in worth for years. At a later date the Board destroyed all notes previous to 1925. Some at least were used as fillings when building the Sanatorium.

It is now an essential part of a house surgeon's duty to provide good notes and the duty of the Records department both to store them and have them readily available. It was not till 1958 that reasonable premises were found for the Records staff in the visitors' old waiting room and for their files in the basement underneath. For twenty years this department has been controlled by Mr Clayton, son of Dr Clayton, former medical officer of the charitable aid Board. That he now has adequate facilities is due to the steady insistence of members of the staff prominent among whom has been Mr L. A. Bennett.

By the early thirties the hospital, more by accident than design, began the nucleus of a library through the heads of the departments subscribing to at least one journal devoted to their own specialties. These were stored in the department and lent as required. About the same time the Medical Club was started. The moving spirit was the late Dr T. A. MacGibbon. It comprised about a dozen members of the hospital staff representing special fields. It met monthly for papers and discussions and at less frequent intervals for social purposes. It also began to collect a small library.

The first formal suggestion of a hospital library was advanced by Dr Pearson at a staff executive meeting in May 1933. Eventually it was decided to amalgamate the hospital journals with the library of the Medical Club, call it the Canterbury Medical Library, control it by a special library committee and with these few journals and much faith in the future,

await developments. The library was thus born in May 1934 with Dr John Guthrie as its first chairman.

At the end of the first year the membership was 67. One of these was Dr C. J. C. Britton the assistant pathologist who was proficient in many fields but who was a genius in library organisation. He became secretary and by the end of the second year had increased the membership to 100, had secured a grant of £100 from the Travis bequest, had devised the mailing system and had arranged for a regular supply of journals from private doctors. He returned to London in 1936 but his interest in the library continued. During the war he procured a grant of £150 from the Wellcome Trust which since then has given over £1600 to the library. He was periodically sent a food parcel and whenever a new edition of Whitby and Britton's text book on haematology is published he forwards an autographed copy.

During the war the library barely survived owing to the difficulties of finance. The membership had fallen, the price of journals increased, the Travis bequest had stopped and there was an adverse exchange rate in New Zealand. In 1952 an appeal was made to the Board to supplement the £100 it had been giving for some years. The Board responded generously. It reorganised the whole committee to include its own representatives along with those of the staff and the B.M.A. This committee was to control all the books and journals of all the Board's institutions. It also made an annual grant of approximately £600 and paid the salary of the librarian. Thereafter although there were few profits there was at least financial security.

Of the many friends of the library some have shown outstanding loyalty. One has been Mr Murray, hospital biochemist. He was the honorary secretary during the war and in effect was at times the sole executive officer. No praise can be too high for his interest and efforts over the last twenty years. Another is Dr G. C. T. Burns, the honorary librarian who since the war has unselfishly given much time to the day to day control. Still another is Dr Hand Newton, author of the *Christchurch Hospital Medical Manual*. There must be few libraries in the world where one of its members has written a book,

placed it on the shelves and donated all the royalties to the library funds.

From the beginning there has been a succession of librarians. Their stipends were very low and not unreasonably they found that their ambition took them elsewhere. This changed in 1952 when Mrs D. Shearer, the first trained librarian, was appointed. The library has since doubled in value. Previously the clinician would enter the library to look for the elusive text. Now he enters to look for the librarian and to explain his problem. The appropriate journals are shortly afterwards on his desk.

The first to receive the honour of life membership of the library was Dr Fox when he retired from the committee in 1936. The second was Dr Britton. Others were Dr MacGibbon (1943) for his work in securing the library of the medical club, Dr Hand Newton (1948), Mr W. M. Cotter (1958) on completion of his second term as chairman and Dr Restell Thomas (1958) who had been honorary auditor for over twenty years.

The various chairmen have been :

Dr J. Guthrie	1934-1939	Dr J. F. Landreth	1949-1954
Dr P. A. Ardagh	1939-1940	Dr Denis Stewart	1954-1957
Dr F. O. Bennett	1940-1941	Mr W. M. Cotter	1957-1958
Mr W. M. Cotter	1941-1949	Dr W. J. Smith	1958-

In this list the name of Dr P. A. Ardagh calls for special comment. Though not a member of the hospital staff he was widely known and respected both in and outside the profession for his integrity, personal worth and surgical ability. After a highly distinguished career in both wars he died suddenly at the War Office in London in 1944. In 1947 the members of the B.M.A. subscribed £169 for a memorial fund. The library committee has increased this to £500 which is invested in hospital debentures and the interest applied to the purchase and appropriate embossing of the *Quarterly Cumulative Index of Medicine*. The hospital has also benefited by the endowment of four cots in the children's ward and the creation of a book prize for the best medical student of each year as decided by the Branch Faculty. Both these were given by the Canterbury

Trotting Club as a memorial to Dr Ardagh. Mr J. W. Ardagh, at present a surgeon on the hospital staff is a son.

The library through the courtesy of the Board was housed for the first 26 years in the nurses' old lecture room which was vacated when the nurses' school was formed on the floor above. In 1960 the pathology department invaded the library which was forced to take up new defensive positions in the old sewing room round the corner. The old area was small and the new area is smaller and quite inadequate for nearly 200 members and nearly 200 journals. The Board has attempted to offset this by skilful modernising of the premises and the new library is an improvement on the old in all except space.

CHAPTER TWENTY-TWO

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The Department of Engineering

THE CHRISTCHURCH HOSPITAL FOR ITS FIRST TWENTY FIVE years had no electricity, no sewerage system, no sterilisation and was heated only by open fires. It therefore had no engineers. It was purely a large house for the sick with a domestic outlook. But from the beginning there was a laundry relying on coal-fired coppers for its hot water. It had a drying room which was locally and elaborately designed but which would not dry. In 1888 the House Committee referred the matter of the wet wash to Mr Scott, a local engineer, who advocated a large increase in the area of drying pipes which would require in turn a boiler. This boiler, he said, should be of such a size that it could be utilised for other heating purposes. The Board immediately thought of wards 4 and 5, large, bare and cold after the gaunt central fireplaces had been removed. It thought too of the theatre and the ward kitchens where heating was defective. It saw the possibility of solving many problems with one boiler, and so approved the scheme, had the plans modified by Mr Scott and called for three separate tenders—a boiler house and stack (Webster & Co. £241), remodelling the drying room (Taylor & Oakley £126) and a ten horse power boiler, later changed to fourteen on the advice of the contractors (Scott Bros. £242).

The boiler house was therefore erected in 1889. It was placed in the centre of all the areas it was to serve, at the rear of wards 4 and 5 and equidistant, where in fact a small portion of it still is. The boiler was installed, the fire was lit, the valves were turned and heat—conveyed, conducted and radiated—began to be felt in wards 4 and 5.

Not that it was perfect. The honorary staff approved the principle but criticised some of the details. It desired an even heat, not a fluctuating one. It wanted hot water continually available for emergencies. Further, both the staff and patients found it hard to tolerate the clanging noises from the pipes.

The contractors successfully dealt with the criticisms one by one. Within a short period the system was extended to ward 6 and the new kitchen and to the theatre. By 1890 the engineering department was solidly established. As a result the water requirements increased and a new ram was installed capable of delivering 250 gallons an hour. Two years later a steam pump was needed for supplementing the water supply. In 1892 the Inspector of Machinery advised duplicate boilers and an extra one was installed. Three years previously a carpenter's shop had been erected (£36). A modest beginning was made to the paraphernalia of the modern engineer. In 1890 a set of stocks and dies was purchased, and the next year a portable forge (£5). In 1895 another £5 was spent on a drilling machine.

The new department meant that for the first time an engineer had to be appointed. When the first boiler was being installed one of the workmen, G. W. Loughton, showed considerable interest. The installing engineer in handing over to the Board recommended Mr Loughton as a suitable boiler man. The Board concurred and also appointed an assistant boiler man. Two months later both men nearly lost their jobs. It appeared that a month before, the assistant had let the boiler run dry. Mr Loughton, though satisfied that no harm had been done, had not reported his assistant to the Board. A motion for their dismissal came before the Board but was replaced by a stern reprimand. The incident focused some attention on Mr Loughton and it was alleged at a Board meeting that his appointment was illegal in that it had not been advertised. So he was given notice, the advertisement was inserted, the twenty five replies were considered, Mr Loughton was re-appointed and everyone was satisfied. The two engineers worked in shifts from 6 a.m. to 9 p.m. At that hour the fires were banked up and it became the duty of the night watchman to supervise them.

For the last decade of the century the Engineering Department was mainly concerned with water—hot and cold. But the

scope steadily extended. Mr Loughton was energetic, versatile and jealous of the good name of his department. Whereas previously the Board had had to resort to plans, tenders and contracts with private firms, now it found that it could with confidence entrust to the engineers asphaltting, concreting, repairs, metal work, drains and minor buildings.

In 1893 the Board decided that the irritations of surplus steam going to waste and an annual gas bill for £300 could best be met by installing an electric light plant. Less easy to decide was the size of plant which steadily grew in prospect as the Nurses' Home (1895) and the Marks Wards (1897) were erected. It was not till 1898 that the plant was ordered (£1440). By this time there was no surplus steam and a new 18 h.p. Cornish boiler (£827) had to be procured along with a duplex steam pump and all this necessitated a new wing to the boiler house. During the installation Mr G. Roberts resigned from the staff of the Islington Freezing works to become the Board's first electrical engineer. At last it was all finished and on the night of October 1, 1899 the 400 lights of the Christchurch hospital blazed forth.

Once committed to electricity the Board found that the load of power and therefore the load of responsibility was always increasing. Some lights had to be maintained all night but it would be wasteful to run the main generator for this purpose. So in 1902 a Parker dynamo (1100 revs) was installed and about midnight was connected to the laundry engine and supplied 140 lights of 16 candle power each. (This dynamo persisted till 1952.) Further dynamos were purchased in 1916 and again in 1920. These were D.C. sets. But as some of the lifts and some of the delicate hospital apparatus required A.C. this was supplied by bringing power from Coleridge. Through the years more and more A.C. power has been needed until there were eventually five points of entry instead of the one demanded by the regulations. Finally the Power Board won and in 1958 the hospital ceased producing its own power except for such as may be required from a 100 k.w. diesel standby plant.

From light to heat. Before the first war the Board was informed that the steam heating system for wards in Dunedin was very much better than the water heating system in Christ-

church. Mr Loughton was sent down to investigate and came back full of enthusiasm. The installation in Christchurch was completed by 1913 at a cost of £326. It included some original and ingenious features for which Mr Loughton was congratulated by the Board. In the same year the engine house was enlarged (Clarke Bros. Construction Coy., £1850). During the construction of the administration block in 1915 the department installed another 49 radiators (as well as all requirements of electricity, water, drainage and, finally, the asphaltting). By the end of that year there were 6642 running feet of heating pipes throughout the hospital.

From heat to water. The supply has always come from artesian sources in the hospital grounds. By 1911 the hospital was using 36,000 gallons a day. In 1930 a new well (90 feet by 7 inches) supplied 120 gallons a minute. To get height for pressure a ram was first used and then at the end of the century was replaced by the ugly tankstands already described. These were demolished in 1914 to make room for the administration block and were replaced by a 60 feet high steel structure with tanks for 4000 gallons. At present the water is pumped to balance tanks on the top of the new Nurses' Home and is reticulated throughout the hospital from this main pipe line. The tanks are the maximum that the bylaws will permit but are not very large and if the pumping ceased would empty in about twenty minutes. Through this system flows the 36,000,000 gallons of water used every year. For fire fighting purposes a 4 inch main from the city supply runs from ward 12 down the front of the hospital to Oxford Terrace.

It is utterly impossible to give an orderly description of the development of the engineering department because there was no order about it. The hospital expanded but the engineers always had to expand first to meet the new need. They were forever installing new boilers and often enough enlarging their premises for the purpose. But the spread of the department was into a contracting field being compressed by wards, the administrative block and the nurses' home. In 1914 it had to accommodate the carpenters as they moved from the original workshops near the chapel. But it later acquired part of the top storey of the laundry which had been added in 1923.

The records of the department have many references to compressors, draught fans, economisers, steam pumps, mechanical stokers and various massive equipment which to the layman is incomprehensible in function and unidentifiable on inspection. But no layman can regard as obscure the obtrusiveness of the engineers' chimney stack. The first one in 1889 was a modest little monument to the department's single boiler. The installation of two boilers in 1893 demanded something more pretentious which persisted till 1920 when a third boiler became necessary to drive the new generating set and to deal with the recent provision of a destructor. Owing to the poor foundations the chimney had to be as light as possible. It was designed by Collins and West, was 120 feet high and was built in concrete by the engineering staff. This is the present chimney, functionally efficient, dominating the landscape, moody in its smoky output and socially unacceptable in the civic neighbourhood. The privilege of laying the last brick on the stack was offered to any Board member but there were no volunteers. It was finally laid by the matron (Miss Muir).

There came a stage when it was no longer possible for the engineering department to remain static in the centre of an expanding hospital. This, and the necessity for a specialist outpatient service were some of the factors responsible for the Board acquiring the St Andrew's manse site and the neighbouring area in St Asaph Street. Here were built the new laundry and the bulk store. The original intention was to transfer the whole engineering department as well. The scheme involved building a subway under the road not only for the transport of patients and goods but for steam pipes. The subway was abandoned mainly because of cost. At that time the new Cashmere Hospital was expected to be all-electric and the plans provided for electrode boilers at certain load centres to provide full steam requirements. Such boilers would be cheap, clean, compact (boilers were only 30 inches in diameter) and would not require constant supervision. The Board was immediately attracted to the idea of installing such equipment at the Christchurch Hospital. But the Government insisted on gas at Cashmere and on coal at Christchurch. At first therefore the only advantage to the engineers of the new buildings on the manse

site was that there was now more room on the old one. But there was further help in 1947. The new laundry boiler, running a full twenty four hours' service had steam to spare. A four inch steam main in a precast section trench was then run under the road between the laundry and the hospital. At the present day, when seepage water has come in contact with the hot pipes the steam so generated may be seen escaping through the road surface. This was the second time the laundry had come to the help of the engineers.

In 1951 two old boilers, both in use for fifty years, had reached the stage where their safety was in question. They were replaced by two others with mechanical stokers. Although, because of uncertain future policy, they were chosen for their cheapness and ease of installation they, with a few items of additional equipment, cost £12,353.

It is time to return to Mr Loughton who started his department in the depression of the eighties and was still in charge in the depression of the thirties. His first leisure was in 1930 when he was granted nine months' leave of absence to visit England. He returned and resumed control again but resigned within a year and retired to England where he died a few years later.

It is a reasonable claim that if a list were compiled of those who through loyalty and merit and the labour of a lifetime have most merited the gratitude of the hospital, Mr Loughton should be considered along with Dr Fox and Dr Pearson. He was engineer for forty three years. On his appointment he had one boiler to look after and the Board, fearful that he might have some idle time, bought him a bench and a vice. When he retired he controlled a staff of eleven and the power, heat, light and drainage of twenty institutions from Kaikoura to the Chathams and back to Ashburton.

Mr Loughton, during his absence in England, was replaced by Mr Drummond who was electrical engineer at the time. He was confirmed in this appointment when Mr Loughton retired. There was some discussion on the Board as to which was the more important function of the department—electricity or steam—as a method of deciding what should be the main qualification of an engineer in chief. No decision was reached

but in 1935 Mr A. Wilson was appointed assistant engineer and the following year was placed in charge of all steam and mechanical services. When Mr Drummond retired in 1940, Mr Wilson became engineer in chief. He is due to retire in 1962. In efficiency, progressiveness and inventiveness he has measured up to the high standard of his two predecessors. But he has greater administrative responsibilities. He supervises a staff of over thirty including maintenance engineers, electricians, leading hands, fitters, plumbers, engine drivers and labourers. This establishment also serves the Board's other institutions. There is a maintenance engineer in charge at Burwood with a permanent staff of about seven and another at Princess Margaret with a staff of twelve. In addition the Christchurch centre maintains the labour pool which deals with the engineering problems of the smaller hospitals and other institutions.

The advance from a boiler to a department was a natural one but the special merit of the hospital engineers is their awareness that they must be adaptable to the peculiar needs of the hospital. They have always responded to the unusual call and often have anticipated it. Their critics are always contesting their priorities but never their efficiency. In 1910 when scarlet fever was serious and sterilisation important the disinfectant from the Sanatorium was installed in a separate room at the hospital and so arranged that infected linen could be fed in at one end and aseptically received at the other. In 1912 the department was asked to experiment with invalid chairs and produced seven superior to the standard article in design, workmanship and cost. The present telephone system with attendants at a central switch board was the result of a suggestion by Mr Loughton in 1912. In 1926 wireless was a novelty and a set was purchased for relaying throughout the whole hospital. The cost was met by many donations, the main item being a sum of £404 from public subscriptions organised by the *Sun* newspaper. The set was then installed by the engineers. When special pins were required for use in Dr MacGibbon's first bronchoscope to facilitate extraction of foreign bodies from the lungs the engineering department made them. It also installed the loud speaker system in 1936. It has

been called on innumerable times for the maintenance of delicate instruments and the servicing of special equipment.

In the general expansion of hospital buildings the engineering department must always be in the van for without its resources a new building is but a dead shell. It follows that the intended rebuilding of Christchurch hospital must be preceded by a major reorganisation of the department. A new boiler house is projected on the manse site behind St Andrew's outpatients and will require the removal of the old kindergarten. The whole department will then be grouped in this area, the logical one as of old on the fringe of the hospital.

CHAPTER TWENTY-THREE



The Later Nurse

ON THE EVE OF THE FIRST WAR THERE WERE 100 NURSES IN all the Board's institutions and 81 were in the hospital. It was a tidy and compact group and because of judicious interchanges between hospitals was adequate.

Suddenly within a few years it became perplexingly inadequate. The war disrupted family and personal life and though nurses were under a promise to stay four years (first instituted in 1910) many could not do so. Twenty eight nurses went on active service. Epidemics at Burwood and expansions at the Sanatorium necessitated more staff. After the war came the confusion of the influenza epidemic and then the establishment of the orthopaedic unit requiring an additional 25 nurses. For the first time in the history of the hospital there began to be a shortage of nurses.

When the supply is short the price hardens. Improvements in the amenities for nurses began from this period and except for the grey years of the depression the trend has continued though it was slow to gain momentum in Christchurch. The motive was something better than pure bribery. Nurses command a special confidence and sympathy in popular esteem and among their best friends has been that pool of potential patients, the public itself.

One example of this was in 1920 when Miss Maude, addressing the Council of Churches on nursing generally, stated that the Board did not look after its nurses, subjected them to overwork and exhaustion and that some early deaths had resulted. Unknown to her there was a reporter present and when the address was published the Board was indignant, Dr Fox

was cynical, Miss Maude was apologetic claiming misrepresentation and many of the public, including some nurses, bluntly stated that even if Miss Maude had not made the alleged statements it was time some one did. In the subsequent campaign for justice for nurses the current schedule of duties was quoted:

Sisters	Nine hour day. Leave: half day per week, half day on Sundays, one full day per month and four weeks' holiday per year.
Staff Nurse	Nine hour day. Leave: half day per week, one full day per month, three weeks' holiday per year.
Nurse in Training	Eight hour day. Leave: half a day off per week, one day off per fortnight, three weeks' holiday per year. Study in own time.

All this averaged out at over 50 hours per week and might have been defensible if it had been honoured. But it was not. Whenever a ward crisis occurred (and every ward has some crisis every day) the nurses had to work longer and often had to forego their leave.

When an indignant public learned of this it girded on the armour of righteousness and went forth to do battle with the Board. And the Board could neither defend nor capitulate. It could not foretell such events as the influenza epidemic of 1923, or the incidence of sickness among the nurses themselves or the rapid increase of hospital beds. There was only one course open to it—to expand on generous lines the number of nurses. But the nurses were not available and had they been there was no accommodation for them. The Board itself approved the ideal but was confused by the practical. Some like Mrs McCombs, the Rev. J. K. Archer and Mr Leadley campaigned tirelessly for more leisure for the nurses, bargaining a fig for the consequences. In 1923 the Government peremptorily ordered all Boards to grant every nurse one day off each week. The North Canterbury Board compromised with one day a fortnight and engaged another 28 nurses. But these were soon

swamped in the flood of winter illness and the one day a fortnight was cancelled.

The public kept the pressure up but from a new angle. The health of the nurses it claimed was being undermined by excessive work. In 1926 the Board held a special investigation into this and found the charge not proved. The critics were not satisfied. In 1928 a regulation was made that all nurses should be medically examined twice a year by Dr Fox. The least enthusiastic participant in this scheme was Dr Fox who knew the limited value of such examinations. In 1930 he persuaded the Board to change this to yearly examinations, Mrs McCombs strongly objecting.

Then came the depression and, as with other sections, the hard lot of the nurses became harder. Their work increased, their leave was slashed and their wages were cut by ten per cent. Since 1925 they had had to contribute to a compulsory superannuation scheme. (The retiring age was set in 1930 at fifty five.) But they had to contribute on the original scale and not on the nine tenths that they actually received. Their net receipts were 7s 1d a week for the first year, 10s 5d in the second year and 13s 9d in the third. It was a miserable wage even in the depression. The City Council in paying its levy pointed this out to the Board and said bluntly that it would have been prepared to pay a higher levy provided it had a guarantee that the nurses would get it. But the Board would not be moved despite a militant minority of Labour members. Mr Archer at one stage even moved that the finance committee be dismissed as not retaining the confidence of the Board. Finally in 1935 the cuts were restored in two stages.

This marked the end temporarily of what was, despite the triviality of the detail, a strong public attempt to improve the status of the nursing profession. It was a successful attempt for it brought together in defence of the nurses a number of unrelated bodies. It was all the more successful because the nurses themselves took no active part in it. During this period they, overworked and underpaid, went on nursing the sick and the battle was fought over them and not by them.

There has however to be sympathy for the Board. The enormous problems of charitable aid during the depression when

hundreds were undernourished were in direct conflict with the claim that special privileges should be granted to one group. Owing to the unemployment there was a very large waiting list of girls desirous of beginning their training. The Board could not overlook the fact that though the conditions were stringent they were at least acceptable.

The impasse over the one day a week holiday was, as the Board so frequently pointed out, a direct result of shortage of accommodation. Up to 1935 nurses had lived in the attics of the old wards, in the Nurses' Home and its extension, in two houses in Cambridge Terrace, in the second ward 3 and the third ward 3, in ward 14, in the medical superintendent's house and the top floor of the administration block. There was only one solution—a new nurses' home. And there was only one obstacle to that—the approval of a site.

The full melancholy story of this search for a site is a chronology of tedious conflict and indecision occupying many pages. In a history of mass motivations it might be worthy of record. In a history of the hospital it merits a short precis only.

In 1922 the Board put £31,000 on the estimates for a new home. It was to be built on the vegetable garden known as the cabbage patch where the tennis courts now are. This was approximately the site selected for the previous nurses' home and special legislation in 1893 had approved of the land being used for this purpose. But then an awkward clause was discovered stating that the Act was invalid if building did not start within twelve months. A new Act would be equally invalid because the Domains Board stated that it would now withdraw its previous consent.

Other sites were suggested—on St Andrews manse area, in Oxford Terrace near the Royal Hotel, somewhere or anywhere remotely distant from the hospital or in an area belonging to the Acclimatisation Society known as the horse paddock (where the home now stands). The groups involved were the Board (suppliant), the Domains Board (cautious and suspicious), the Acclimatisation Society (compensation conscious), the Government (impecunious but otherwise indifferent), and the citizenry of Christchurch (implacably dedicated to a policy of disagreement).

The Board was divided. Mrs McCombs on the Board and her husband in the House strenuously opposed any home in the hospital's vicinity. Labour members of Parliament clashed in Wellington. The United Burgesses' Association, the Spreydon Burgesses' Association and the motion movers at a public meeting supplied answers to questions that had not been asked. At one stage the issue became snarled up with a search for a site for the McDougall Art Gallery and on a fringe issue the Board received a protest from a nebulous body identifying themselves as 'The artists and art lovers of Christchurch'. A ballot was held among the nurses as to their preference for their new home and all favoured the horse paddock with the exception of two who preferred Warners Hotel and the United Service. Wearily meeting followed meeting, deputations met Boards and Boards appointed deputations. There was a steady traffic to and from Wellington. Suggestions met with counter-suggestions and while the years passed the nurses, scattered like nomads in the desert, went on working.

In 1928 Parliament intervened, rather as a tolerant parent will yet insist on a limit to the squabbles of the children. The Christchurch Hospital Act Amendment Bill was passed. Its main clauses were that the Board was to get the horse paddock, the Domains Board was to get the cabbage patch, the Acclimatisation Society was to get £2000 and the building was to start within a year. Mrs McCombs and Mr Sullivan strongly opposed it while other Canterbury members of the House supported it. The *Lyttelton Times* deplored it; the *Sun* approved it.

The Board, fearing any possible consequences of further delay, acted speedily. Plans were prepared by the architects, Messrs Collins and West. Tenders were submitted, that of Messrs J. W. Beanland and Sons accepted for £54,000, the contract was signed and immediately after, the contractors and the Board were entertained by the Chairman (Mr Otley) to luncheon at the Royal Hotel.

The whole business was not a bright chapter in our civic history. Every tentative suggestion became battered on the rocks of opposition. The horse paddock was described as the boggiest and foggiest site in Christchurch. Some wanted the

home at Cashmere or Burwood and some even wanted to shift the whole hospital. There was the usual hysteria over the use of Hagley Park. The *Sun* newspaper commented on this. 'It is pushing a sound principle to an unreasonable extreme to refuse to surrender an unimportant angle of the park for a most important public use'. At the time destitute old women were sleeping out in the park at night without much public comment and less public protest. There was no effective leadership, no co-operation and little community spirit. There were many who with nothing constructive to offer were yet dedicated to a campaign of obstruction. The whole matter at the time was serious. The hospital desperately needed more beds. It could not get them till it had more nurses and it could not get these till it had a home. The impasse was after all a reflex of the times. The depression was deepening and poverty and anxiety were increasing. The measures taken by the authorities were not effective and there was a growing mistrust of those in power. Criticism tended to cease to be constructive and to become automatic. The criticism never extended to the nurses who took no part in the controversy and were never begrudged what they got.

The contractors set to work. The foundations were unsatisfactory and 150 concrete piles each 35 feet long had to be driven at a cost of an extra £6000. Another £2000 had to be spent in modifying the plans in accord with the new building regulations after the Napier earthquake. The Board had difficulty with the Loans Board in raising this money. In 1932 the Domains Board, affable again, rented the cabbage patch to the Hospital Board for £6 per year as a site for the present tennis courts.

The foundation stone was laid by Mr Otley in 1931. Thereafter building progressed smoothly and, because of the surplus labour pool, fairly rapidly. It was a massive steel framed structure of ferro-concrete and was originally of three storeys. An extra three storeys were added in 1941 as had been planned from the beginning. These cost about £62,000. The total cost including furnishings has been approximately £135,000. It now accommodates 259 nurses. It is one of the finest buildings in

the city and there are probably few nurses' homes in the world which exist in a more lovely setting.

A happy contrast to the conflict over the nurses' home was the smooth origin of the Nurses' Memorial Chapel. A chapel for the use of patients and staff was first suggested to the Board by Miss Thurston in 1914. On October 23, 1915 the English hospital ship, the *Marquette*, was torpedoed in the Gulf of Salonika and ten New Zealand sisters lost their lives. Dr Fenwick, then on active service, wrote to the Board suggesting that a chapel would be a suitable memorial to the three victims from the Christchurch hospital. The Board concurred and appointed a committee to maintain interest and receive funds, the first of which came from the offertory at a memorial service held in St Michael's church in 1917. The idea grew in favour and in 1925 a new Nurses' Memorial Chapel Committee, embracing all denominations, was formed. The main officers were Dr Fox (chairman), and Messrs H. D. Andrews (honorary treasurer), J. W. Baty (honorary secretary) and W. E. Leadley (organiser). The Department disapproved of the first suggested site where the radiotherapy department now is but had no objection to the second choice which is the present site.

The public subscribed liberally and the money was soon raised. The plans were prepared free by Mr Collins. The Board provided the foundations and also a storage basement which it retained for its own purposes. The cost of the chapel was £3486. This left a surplus in the fund of £148 which was handed over to the Hospital Lady Visitors' Association for chapel furnishings.

The foundation stone was laid by the Duke of York on March 15, 1927. The first service was held on Christmas Day of the same year and on July 25, 1928 the chapel was formally transferred to the Board.

No description is necessary of the interior of this beautiful portion of hospital property for the doors are never locked and all may enter and see. All the main denominations hold their respective services there. It was the first public hospital chapel in New Zealand. Its own local history is recorded and maintained in a silver casket set in the wall, the casket being presented by Dr Fox on his retirement in 1936. The chapel has

in many ways become the repository of the hospital archives. On the entrance wall are numerous brass plaques in memory of many who have given their lives in the service of the hospital or the service of the sick. Though it was originally a memorial to nurses and should retain its name for this reason it now in a wider concept embraces the spirit of sacrifice which transcends all sections and groups.

Previous to 1923 the training of nurses was on severely practical lines. When Miss Muir returned from an overseas trip in 1923 she had gathered new ideas and, with the Board's approval, established the first nurses' training school in New Zealand. The curriculum was enlarged and a tutor sister (Sister Christmas) was appointed. Nurses were admitted twice a year to a three months' probationary course (later, owing to a shortage of nurses, reduced to one month). A cooking school was set up in a corner of the first nurses' home where later the cafeteria was established. (Previously the nurses learned cooking at the Technical College.) The demonstration room was in one of the old theatres (now part of the radiotherapy block) which fell vacant when new theatres were built on the present site in 1922. There was one lecture room in that part of the pathology department which before 1960 was the Canterbury medical library. The school was an immediate success, was copied in other centres and led to a reorganisation of the nursing services throughout the country.

When the new nurses' home was built in 1931, and thereafter accommodated the nurses who had been living on the top floor of the administration block, the vacated area became the new school. Two lecture rooms were built, a model ward installed, a library equipped and a cooking school fitted up. The whole school thereby became fused into one compact block. As such it has persisted for thirty years with some improvements but no radical alterations during that time. Over 2000 nurses have gone through this school. Like all training schools it is a place of vivid memories and mixed emotions. It has been both the challenge and the despair of a long succession of tutor sisters. To the nurses it is the place with the hard seats and the weary complexities of human anatomy and physiology, and the futile fight to keep awake at the end of a long hot day. To the doctor

lecturing there the school is remembered for its bad acoustics and, when the No. 8 tram ground round the hospital corner, for the failure of the human voice to compete. To the new probationer, formerly stiff with pink, it has been a place of awe. To the post graduate committee, wandering round the hospital looking for a quiet corner, it was in the late forties and the early fifties a precious haven until the inauguration of the nurses' study day each week. Thereafter a few gentle hints from tutor sisters forced the committee to realise that the obligations of chivalry were greater than those of clinics and it departed and invaded the gymnasium from which it was rapidly evicted.

To all who know it, it has been a good school, standing high among the schools of the Dominion with its graduates spread world wide, both in war and peace. It is remembered with affection by many of the matrons of New Zealand hospitals. It has contributed to the ease and comfort of hundreds of thousands of sick people. It is weighted with traditions and now lacks only an archivist to preserve them.

A personal and practical testimony to the worth of the nurses was the creation of the Hamilton Prize. Bertram Eli Hamilton was an Englishman coming from Brooklands Sale in the county of Chester. After serving as a lieutenant in the Imperial forces in the first war he came to New Zealand as a farming cadet. He first studied in the North Island and then for eighteen months was a student at Lincoln College. There his health broke down and he was for three months a patient in Christchurch hospital. On his recovery he left New Zealand and died shortly afterwards in Paris.

His will directed that his executors should set aside a sum sufficient to produce an annual income of approximately £75 and that this should be a 'prize, exhibition or grant' to the nurse on the staff of the Christchurch hospital best qualified to receive it. He made it plain that the bequest was a tribute to the nursing treatment he had received since the war. He directed that the decision should be made by the popular vote of the nursing staff and this procedure has been followed since, nurses being entitled to one vote and sisters to two. The bequest is

administered by the Guardian Trust which remits the annual income to the Board.

In 1946 a forty hour week was approved after much discussion by the Board. One section maintained that the nurses should have what the rest of the community enjoyed. The other insisted that though this might be reasonable it was not feasible. In the end both parties won. The Board approved a forty hour week and the nurses went on working for forty four though they were now paid overtime. In 1942 the regulations were waived whereby a nurse had to have at least two years' secondary education though more recently the rule has been reinstated and sometimes the applicant has to pass a hospital examination in general knowledge. In 1952 the Board decided to issue free a silver medal—the Christchurch Hospital Medal—to all nurses who stayed on the staff for a fourth year, and those who had qualified previous to this date were allowed to buy the medal. In 1948 there began the system of the one study day each week.

In 1948 the Student Nurses' Association asked the Board for a recreation hall. A suggestion was made by Miss Howard that this might be erected on top of the nurses' home but architectural difficulties forbade. The nurses began to collect towards a building fund and had this augmented by a generous donation. The objective was reached by means of a Board subsidy of £12,000 from the Amalgamated Trust Fund.

The site selected was in front of the nurses' home. This very fine building with its central hall and stage was commenced in 1957 and finished in 1958. A wistful comment has been made by some Board members that it would make an excellent ward for chronic cases were it not for the awkward legislation of 1887.

Despite the fact that the new hall includes a modified training school for probationers, the building itself and particularly its environment emphasise the recreational potentialities. The hall and the home are flanked by a garden where in the spring over a million daffodils bloom. The tennis season opens with no recollection of the battles that have been fought over the cabbage patch. When in 1954 the Domains Board decided to erect an instrument shed on the other side of the river a depu-

tation of nurses, blissfully ignorant of the history of their own home, were in the forefront of those whose opposition to building in Hagley Park blocked the attempt. The nurses have started to perpetuate their own traditions in the landscape. At the request of Miss Widdowson one of the army sisters in the last war brought back a cone from the cedars of Lebanon. In the nursery garden a sapling was raised from this and in 1954 the tree was planted by Mrs Lawn, wife of the chairman of the Board, to commemorate the war service of the Christchurch hospital sisters.

The administrative problems that result from the control of all the nursing staff in the Board's employ are undertaken in the first instance by the Lady Superintendent in Chief, Mrs M. Chambers. She has the personality that can easily accept responsibility and the task is confidently performed. She has modified the relationships between the nurses and the institutions in which they work. There is less insistence on a rigid code of rules and more reliance on the self discipline of the individuals. The present nurse, though she may not know it, works in a greater personal freedom than did her predecessors. The organisation and control is of course too great a task for one person. Since Miss Rolls became matron of Burwood, Sister H. Childs was deputy Lady Superintendent until her retirement in 1962. At that time the first assistant was Sister L. Murray with Sisters D. Newman and A. Ensor as second assistants.

What has been written has been restricted to the nursing profession in Canterbury. Space will not permit discussion of the wider problems of an ever expanding course of instruction and the risk of a good nurse becoming the pale shadow of a house surgeon, of the mounting criticism of the Nurses and Midwives Board, of the difficulty of maintaining an adequate supply of nurses, and of how to equate the fact that the personality which makes a good nurse also tends to make a good wife and mother with the other fact that such nurses have eventually to choose between hospital and home. To the majority nursing is an interlude. To the few only is it a career. The supply may be precarious but the demand is constant. There is no substitute for a hospital nurse and when she is not

available the hospital has to close. She ranks as one of the greatest medical discoveries of the last century.

CHRISTCHURCH HOSPITAL NURSES' ROLL OF HONOUR

DEATH WHILE ON THE HOSPITAL STAFF OR ON ACTIVE SERVICE

1910 Kirby, A. M.	1944 Crampton, A. S.
1910 Nisbet, J.	(active service)
1915 Hildyard, N.	1947 Barrell, D. R.
(on active service)	(tuberculosis)
1915 Rattray, L.	1947 Williams, B. M.
(active service)	(tuberculosis)
1915 Rogers, M.	1947 Prescott, J. I.
(active service)	(neoplasm)
1918 Beswick, G. C.	1953 Boland, B. M.
(influenza)	(post operative)
1918 Hooker, H. (influenza)	1958 Greenwood, A. M.
1919 Hepple Thompson, M.	(neoplasm)
(result active service)	1958 Cuddon, A.
1920 Watson, L.	(tuberculosis)
(acute septicaemia)	1959 Irwin, M. J.
1923 Rixdon, D.	(tuberculosis)
(tuberculosis)	1961 Watson, W. G.
1929 Barton	(accident)
(tuberculosis)	

FIRST PLACE IN DOMINION STATE FINAL EXAMINATION

1905 Martin	1950 Sutton, P. (December)
1910 (name not recorded)	1952 Kinross, N.
1939 Bell, J.	1954 Cardinal, J. W.
1943 Gardiner, N. M.	1955 Campbell, M. E.
1949 Eagle, L. E.	1956 Ballantyne, M. H.
1950 Hawker, K. M. (June)	1957 Gilmour, V.

WINNERS OF BERTRAM ELI HAMILTON PRIZE

1933 Dickie	1936 Syme, M. F.
1934 Laing, M. S.	1937 Giddings, E.
1934 Kensington, M. E.	1938 Barnett, M.
1935 Garner, N.	1939 Stoddart, T. I.

- | | | | |
|------|-----------------|------|-----------------|
| 1940 | Taylor, J. | 1951 | Taylor, Z. E. |
| 1941 | Scott, H. B. | 1952 | Campbell, H. |
| 1942 | Mitchell, F. | 1953 | McGhie, E. H. |
| 1943 | Orbell, E. | 1954 | Pearton, G. L. |
| 1944 | Jakins, M. | 1955 | McIntosh, E. E. |
| 1945 | Stoddart, R. E. | 1956 | Ensor, A. |
| 1946 | Campbell, H. | 1957 | Tarpey, I. M. |
| 1947 | Read, K. | 1958 | Gardiner, J. Y. |
| 1948 | Harrow, M. | 1959 | Brankin, B. |
| 1949 | Tolerton, I. | 1960 | Murray, L. |
| 1950 | Rolls, S. C. I. | 1961 | Caukwell, P. |

CHAPTER TWENTY-FOUR



Repair and Maintenance

THE WORKS DEPARTMENT

THE WORKS DEPARTMENT IS FAR OLDER IN FUNCTION THOUGH far younger in title than the engineering department. Since the earliest days carpenters, painters, plasterers and gardeners have been almost as constant on the hospital scene as have patients. For the first thirty years they were like sheep without a shepherd. Sometimes they received orders from the house steward, but these could be altered by the secretary who in turn often found that the chairman of the Board had given his own instructions. Sometimes a member of the Board was appointed to supervise a special piece of work. In new building projects the Board often appointed a clerk of works but was inclined to dismiss him as soon as the foundations were safely laid. At the beginning of this century maintenance of old buildings became a major task and continues increasingly. Steadily the maintenance staff grew and less work was submitted to private contract. This staff was under the control of the Engineer until 1917 when the works department was formed. At first the change was an administrative one. Mr W. Harrop, who had for some years been clerk of works on various buildings erected by the Board, was put on the permanent staff in 1917. He was to continue as clerk of works but was also to be responsible for advice, estimates and maintenance of the Board's property at hospital and elsewhere. At the time the Board was careful to reaffirm its confidence in Mr Loughton who could thereby be liberated for more important work. Mr Harrop retired in 1937 and was succeeded by Mr R. A. Rose who was then foreman carpenter. Mr Rose's initial doubts as to his ability were completely allayed by a long and meritorious career terminat-

ing in his retirement in 1953. Within this period the title was changed to superintendent of works. This was due to a distinction being made between erection of new buildings and maintenance of old. The superintendent of works was to control the latter. For the former a new post was created, that of building supervisor. It was first held by Mr Sparks who had been clerk of works for the Public Works Department during the building of the upper sanatorium and much of Burwood hospital. He was followed by the present supervisor, Mr R. H. Paton.

The first carpenters' workshop was a detached building roughly on the present chapel site. The carpenters later moved to the ground floor of the engineering block. They gained more space here in the early thirties when the engineering maintenance workshop was established on the first floor above the engine room and the plumbers' shop was also moved upstairs. In 1951 new carpenters' workshops were built on the manse site at a cost of £25,000.

The present superintendent is Mr D. Prestney, who controls a staff of about forty comprising carpenters, painters, upholsterers, labourers and drainlayer. This is the maintenance headquarters not only for the hospital but for the other institutions of the Board, similar to the organisation of the engineering department.

The busy clinician across the road knows little of the works department. When he clamours for some repairs he usually applies to the wrong quarter and when they have been effected he usually has no idea as to how it has been done. The works department, on the other hand, though knowing less of medicine, knows far more about the hospital, half of which but for them would have tumbled in ruins by now. Theirs is a constant struggle against the relentless processes of decay.

In this struggle are the veterans. Mr Loughton was the first. Mr Harrop and Mr Rose both had long service. Mr Hooper ceased to be foreman upholsterer in 1954 after thirty eight years' service. The record is held by Miss V. M. Jones who joined the clerical staff of the hospital in 1920. In her time she had worked in many departments but all through was officially

a member of the works department from which she retired in 1962.

THE CENTRAL STORE

When the hospital was first built in 1862 no provision had been made for bulk storage. There was indeed little to store. Contractors delivered the goods regularly as required and what was not immediately used was kept in any available space without order or system. In 1863 the Provincial Government appointed Mr Ambrose to enquire into the whole matter of hospital supplies. In the course of his report he said: 'I beg to be permitted to point out that owing to the inadequacy of the means for weighing such articles as flour, sugar and tea I had to take an approximation of the weights as nearly as possible. There being no store room the flour is kept in what is known as the large kitchen on the ground floor, the sugar in an open barrel in the porters' bedroom on the upper floor, the liquors in the matron's parlour and other articles here and there dispersed except the bed furnishings which are all contained in the store room upstairs.'

Some organisation of the storage problem would probably have come sooner if the hospital services and charitable aid had not been established under separate Boards until 1909. The latter Board had to have bulk groceries for supplying rations. These were always kept on the same premises as the Board's offices—first in Montgomery's buildings then in Worcester Street and finally in the Armagh Street depot. In the hospital during the same period stores were scattered wherever there was a convenient space. Some departments, such as pharmacy and engineering, maintained their own bulk supplies.

In 1909 when the two Boards combined, a stores department became essential. The opportunity came in the building of the first stage of the administration block in 1912 when a store was included on the ground floor and covered the area between the new offices and the kitchen. In the second stage a basement was built where the records are now kept and this was also utilised for stores.

Before long two factors made all this inadequate. The country hospitals were building. Their equipment and supplies were first handled in Christchurch. Also during the depression the Board's store became a vast grocery shop where a staff of up to five men spent most of their time weighing and parcelling for the weekly issue. At one stage two tons of sugar a week were divided up into lots never over three pounds. The stores began to spread over the hospital again. Some were kept in the basement of the chapel. The textiles (sometimes up to £60,000 worth) were stored under the extensions of the orthopaedic department. In the worst of the depression even these measures failed and the present ward 15 became the grocery store where those on relief presented their orders. But by 1936 this pressure began to slacken and before long the premises were converted into a ward.

When the store was first built a storeman was appointed to take over from the house steward. At first he lived above the premises but had to vacate this later in order to increase the storage space. But the Board had for a long time been aware that more adequate provision was necessary. Consequently when the St Asaph Street site was acquired a massive bulk store was planned. It was erected in 1957 at a cost of £75,000. It is of concrete and reasonably fireproof. It safeguards the bulk supplies for all the Board's institutions. These supplies cost about £182,000 a year and at any one time the value of the goods in the store is at least £75,000.

The general policy now is that each hospital or home should have its institution store supplied from the central store. The hospital's own store is now located in the old central store which at the end of 1961 was enlarged to include the occupational therapy quarters when this unit moved to ward 15.

The authority for controlling stores was in the early days an ill defined one. At various times it has been the responsibility of the house surgeon, the secretary, the matron or the house steward. When the first store was built in 1912 the first officer to control it was appointed in the person of Mr A. Russell. He was followed in turn by Mr G. Hollingworth (1939-1948), Mr F. T. Hogsden (1948-1955), and then the present officer, Mr A. J. Cameron. These four names cover a period

of nearly fifty years and illustrate that the staff of the store tend to persist. Mr Hogsden was in the store for thirty years. Mr G. F. Simpson, who was head of the dispatch department when he retired in June 1961, had been there for forty years.

In the other two hospitals the institution's store is largely under the control of the house manager. At Princess Margaret hospital this is Mr T. McGuigan who previously held a similar position at Christchurch hospital being followed there by Mr C. H. Dann and the present manager, Mr A. C. Shaw. The manager at Burwood is Mr H. Owles.

THE SEWING DEPARTMENT

Despite this title there is no sewing department in the hospital, but considering the large number of people employed in the making, mending and repairing of garments and fabrics and the very great value of the work performed, some day there may be.

As a class such workers have existed from the early days of the hospital when from time to time a seamstress would be hired at half a crown a day. Later, sewing became the responsibility of the laundry staff. Still later a permanent sewing woman was employed and then two and eventually many. The Hospital Lady Visitors' Association and the Friends of the Hospital have assisted at times but they could not possibly cope with the needs of the hospital.

The first separate premises for the sewing staff were in the house surgeons' old quarters on the first floor of the administration block (now the library). New premises were found in 1951 on the top floor of the bulk store. They comprise two sewing rooms adjoining the laundry sewing room. The intention was to make these two rooms into a small factory for the manufacture of uniforms but there were difficulties and the scheme lapsed. The total of three rooms house about thirty machines.

Despite the importance of their work the women so employed live in a lonesome state from the administrative point of view. They are tenants of the bulk store, get their raw

materials largely from the laundry, and have a function similar to that of the works department. Under these circumstances it is perhaps wise that the Board has placed them under the control of the Lady Superintendent in Chief.

That a career is possible on the sewing staff of the hospital was proved by Mrs Stone who, appointed as a seamstress in 1896, resigned forty years later.

CHAPTER TWENTY-FIVE



Matters Domestic

THE LAUNDRY

THE ORIGINAL HOSPITAL HAD NO LAUNDRY BUT MERELY A washhouse—a small room at the south-western corner of the hospital jumble. Its equipment was a pair of kauri tubs, a copper heated by wood or coal, a mangle, an ironing table and an iron. Its staff was one laundry maid (£40 a year). Its annual costs are not recorded but the estimate for a similar laundry at the Lyttelton hospital at the same time was £50.

The history of the laundry is easy to detail for it is a series of episodes separated by long periods of silence. The first such silence was broken in 1874 when the laundry maid plaintively intimated that she would find an assistant very useful. This prompted the Provincial Council to look into laundry matters and it hastily tried to make amends. The washhouse became the laundry; the laundry maid became the laundress; her assistant was appointed (£26 a year) and the laundry started to become mechanised. This was done in 1875 by importing from London a washing machine, a drying machine, a mangle, a wringer and a traverser, all hand operated, at a total cost of a little over £50.

Then, till the end of the century, there came another silence, not quite absolute because in 1889 the engineers came blundering into the laundry and the drying room with their steam and because in 1897 the Board, for some inexplicable reason, set not the maximum but the minimum wage for the female workers in the laundry (3/6 per day with food). The motive may have been contrition for in 1900 the hospital committee referred to the laundry as being beyond redemption. The drying room was obsolete and the staff was 'working under the most

primitive and adverse conditions with no modern appliances'.

The Board had to admit that this was strong language and put £1000 on the estimates for a new laundry. The obvious site was near the centre of the hospital and next the boiler house. It was less easy to decide on the type of machinery. The most careful investigation was made up and down New Zealand and the order was eventually placed with the Troy Laundry Machine Co. of New York. (The items are too technical and lengthy to detail. The landed cost was about £355.) The new laundry was built by Messrs F. Turvey and Son (£1014) and involved the removal of the old mattress room. The installation was tricky and was done by Lucas Bros. (£150). In 1901 the new laundry was in operation and was dealing with about 4500 articles a week and had a reserve potential of about 25 per cent.

All the staff were dismissed (one man and four women), but were free to apply for the new staff (two men and one woman). The old drying room was modified to become a fumigating chamber for bedding. An engine was procured to drive the machinery by day and the Parker dynamo by night.

Thereafter the silences were less marked being often broken by the thud of some heavy piece of machinery being installed and the necessary space being increased. In 1909 the drying room was enlarged. Three years later extensions to the value of £150 included a sorting room and a room for nurses to iron their personal clothing. In 1918 the sum of £1096 was put on the estimates for a new storey on the laundry. This was completed the following year, the contractor being G. L. Bull (£990).

During the depression of the thirties the expenses of the laundry came under close scrutiny and it was decided to close the laundry and accept a contract with Mount Magdala. At the last moment this was cancelled in favour of internal economies. All the staff with the exception of the head laundress (Mrs Parkin) was dismissed but was free to re-apply. The staff then included an assistant laundress (£2/5/-), ten women (35/-), four girls (17/6) and two men at 1/7½d an hour. The control of staff thereafter was to be under the laundry manager who

was to be responsible to the Finance Committee and not, as previously, to the Hospital Committee.

As the depression passed the work increased and the space remained static. A new laundry became an urgent matter. The Board's opportunity came in 1941. An area of land at the corner of Antigua street and St Asaph street was purchased and reserved for a new laundry. It adjoined the manse site on which the new out-patients' block was erected. It was added to in 1945 when the Board purchased an adjoining area for £1800.

The laundry was commenced in 1943 and finished in 1945. It was of ferro-concrete, partly two-storey and cost £50,000. New machinery to the value of £25,000 was installed. It was elaborate, modern, multiple, technical and costly. It was designed to deal with 10,000 lbs of dry wash a day with a capacity to include another 25% if necessary. In 1945 it handled nearly 3 million articles for the year.

The 25% reserve capacity was soon absorbed. In 1952 further extensions were made by the Fletcher Construction Co. (£10,897) and the next year nearly five million articles were washed. The equipment has recently increased. There are now nine washing machines, two Tullis presses and a Lister airspeed drier. The Decondin ironer at the time of its installation was the largest in New Zealand.

In the modern laundry, where most of the work is done by machines, and human agency is needed only to guide the machines, chaos could result if the organisation should falter. Instead the organisation works smoothly but only because it extends over almost the full domain of the Board. In addition to doing the laundry for the new district nursing laundry service and, by special arrangement with the Health Department, for St Helen's Hospital, the laundry deals in whole or part with nineteen other institutions controlled by the Board and the linen in all these last is interchangeable. Only Tuarang, Rangiora and the Chatham Islands provide their own full laundry service.

Hospital linen poses special problems in that articles which are grossly soiled should first have a preliminary wash before being despatched to the laundry. This was done by nurses in

the 'soiled section' of the various wards and was a hazard to sterility. Recently some research has been carried out at Burwood. In this hospital is a central linen section where some light laundry was done and where the staff experimented with dealing with foul washing by bulk. The results were successful and the system of dealing with the foul wash in bulk has now been extended to the main laundry.

It is not possible to describe but it is appropriate to commend the smooth efficiency whereby a hundred laundry workers balance the intake and output of over five tons of dry wash a day or eleven and a half million articles a year. The credit is shared not only by those who operate the machines but by those who supply them. Improvement in equipment has been enormous and to some extent may be illustrated by comparison of costs. Thus the clothes dryer was £200 in 1889 and is now £2985. In 1875 the washing machine was £15 and in 1955 £2310. Hydro extractors at the same dates cost £16 and £1028. In 1900 a collar cuff ironer was purchased for £36. The present flat work ironer was bought for £8200.

THE KITCHEN AND DIETETICS

While the Christchurch Hospital was being built in 1862 the superintendent, Dr Stedman, wrote to the provincial secretary and gave it as his opinion that the projected kitchen was too small. In 1887 it was replaced by the present one which is still too small. Despite this the two hospital kitchens have during that period of time prepared and served probably thirty five million meals.

The kitchen was in the south-west corner of the original block that formed the early hospital. It was like any early country kitchen with a coal stove and very little equipment other than pots and pans. It was controlled by a cook (£40 per annum) and the rest of the staff was a kitchen maid (£20 per annum). The cooked meals were taken from the kitchen in bulk to the wards and there served. There was no method of keeping them heated. When the patients had fed, the nurses had their meals, sometimes in the ward kitchen or pantry,

sometimes in the hospital kitchen, sometimes in their rooms. The ward maids always ate in the kitchen.

There were three diets, which were described as full, light and fever. These were :

FULL	LIGHT	FEVER
Meat $\frac{3}{4}$ lb	Meat $\frac{1}{4}$ lb	Oatmeal 3 ozs or
Bread 1 lb	Bread 1 lb	Arrowroot $1\frac{1}{2}$ ozs or
Tea, coffee or cocoa $\frac{1}{2}$ oz	Tea $\frac{1}{2}$ oz	Sago 3 ozs
Sugar $1\frac{1}{2}$ ozs	Milk $\frac{1}{2}$ pint	Sugar 2 ozs
Butter $1\frac{1}{2}$ ozs	Sugar $1\frac{1}{2}$ ozs	Milk 1 pint
Salt $\frac{1}{2}$ oz	Butter $1\frac{1}{2}$ ozs	Tea $\frac{1}{2}$ oz
Pepper $\frac{1}{4}$ oz weekly	Salt $\frac{1}{2}$ oz	Bread $\frac{1}{4}$ lb
Soap 1 oz	Pepper $\frac{1}{4}$ oz weekly	Butter $1\frac{1}{2}$ ozs
Milk $\frac{1}{2}$ pint	Soap 1 oz	Soap 1 oz
Flour 3 ozs		
Mustard $\frac{1}{4}$ oz weekly		

With such a diet the cook had no need to be a chef and probably never was. The cooking standard at the time was very low. In 1867 the *Lyttelton Times*, always a stern critic of the untidy domestic details of the new province, published an editorial reproof '... of cooks, new even to the use of a saucepan, to whom a pudding is a surprise, pastry an unapproachable mystery and cleanliness a work of supererogation.'

In those early days, as now, food was supplied to the hospital by public tender. The lowest tender was invariably accepted and once the contract was signed it could never be varied in the contractor's favour nor could he transfer the contract if he sold his business. The quality of goods was often in dispute. On many occasions a contractor was ordered to remove a certain consignment and replace it with something better. In the days before cold storage, contractors had many causes of anxiety.

The prophecy of Dr Stedman that the kitchen was too small was soon fulfilled but it had to persist. When, in the seventies, wards 4, 5 and 6 were built the kitchen was not only inefficient but sadly out of place. Dr Grabham, Inspector General, reporting in 1883 on the Christchurch Hospital, referred favourably to the apartments of the house steward and housekeeper and then went on 'I cannot say the same of the kitchen and its offices which are situated at the back of the old buildings. This part of the structure requires rebuilding and the cooking

apparatus replacing as it is extravagant in fuel and in great measure worn out. The scullery is small and offensive smelling, being undermined by rats.'

This stung the Board into cleaning out the kitchen and putting in a new range with the great improvement of two boilers instead of one. More would have been done but, as already narrated, it was the time when drainage held priority over kitchens. By 1887 however nothing could hold priority over the kitchen. Tenders for a new kitchen were called. That of Mr A. Clephane for £723 was accepted and the work was completed the next year.

This is the present kitchen. It has of course been greatly modified and extended since but this has all been done on the basis of the 1888 structure. The site is a good one. It was built more or less in the centre of the hospital and is still there. No sooner was the new kitchen built than the engineers began blowing steam round the hospital and coal ranges became obsolete. In 1889 the new boiler was connected with the kitchen and thereafter the cooking was done by steam.

There was still nothing elegant, however, about the products of the kitchen. For breakfast the patients got porridge which was brought to the ward in a bucket (one patient of 1888 describes how in ward 6 the porridge was brought every morning by a patient who had a fungating cancer of his face). Following the porridge each patient got two slices of buttered bread and, if desired, some jam. For the other meals the food was brought in bulk from the kitchen in large wooden trolleys protected by a tin cover. On the ward table was piled a heap of bare wooden trays on which the food was served to each patient. The crockery was very thick and often chipped. Cups were used without saucers. Nurses (in the nineties) had to purchase their own cutlery. By 1905 they had a separate dining room in the Nurses' Home in which there were long tables, one for the seniors and one for the juniors. The most junior probationer had to hand all the plates across to the seniors before she could start her own meal. The nurses had the same as the patients—although it is probable that extras were provided for both patients and nurses as opportunity permitted. One nurse of those days remembers with appreciation oysters

for breakfast. (So might anyone.) Dr Grabham always approved of the food. He mentions seeing broth, whitebait and 'an abundance of vegetables' being served to the patients. But these were scheduled visits met with adequate preparation. It was the habit then, as now, for convalescent patients to sit at a central table in the ward.

The appointment of a dietitian had been mentioned many times before any positive steps were taken. In 1925 Miss Molyneaux became second assistant matron with charge of the dietary and domestic arrangements. But Dr Fox and the rest of the staff who had to make up diabetic diets, wanted a dietitian. In 1926 the first dietitian, Miss E. M. Reid, a diploma student of the Otago Home Science School, was appointed. The occasion was marked by improvements in the general kitchen and a partitioning of a portion of it to form a special diet kitchen. Miss Reid was responsible for introducing iodised salt. She remained till 1928 and then was tempted away by the Wellington Board. She was not immediately replaced. Miss Molyneaux, with Miss Randall as assistant, was put in charge of the hospital kitchen, the special diet kitchen and the Nurses' Home kitchen. Their duties included not only dietetics but also the control of staff.

In 1925 the Board set aside a small room in the original Nurses' Home for nurses' morning and afternoon teas. It was immediately popular, so popular in fact that the Board felt it should not be restricted to nurses. The tea room was therefore extended and opened as a cafeteria in 1929. The cafeteria has functioned most successfully ever since, as is proved by the fact that it is usually overcrowded. The request has been made a number of times especially by the staff executive that a small cafeteria should be provided for the doctors. It provides facilities for discussion of work and for entertaining visiting medical men. The Board has always been sympathetic but it was not till the end of 1961 that it was able to provide a small annexe capable of seating twelve persons.

The hospital in its long history has spent thousands of pounds on millions of loaves of bread. In the very early days it negotiated a contract with the Lyttelton gaol for bread made by the prisoners. This was mainly for the orphanage but the

arrangement soon lapsed, possibly owing to the baker having completed his sentence. In 1915 the Board discussed establishing its own bakery and aerated water plant—possibly at the rear of the Armagh Street Depot. But other buildings had a more urgent priority and the bakery was deferred until 1936. It was then established in 'the big room on the way to the cafeteria' in what up till the end of 1961 were the premises of the occupational therapy department. The bakery produced an abundance of good bread but it was not cheap. In its first year the bakery supplied over 50,000 four pound loaves, at a cost of £33 per thousand. Private contract previously had supplied the same quantity at approximately £27, though this was at a period when all costs were low. The bakery continued until 1948. It was then operating for too short a period at night and could not take full advantage of the cheap power rates. After the bakery closed, bread was again supplied by private contract.

The original garden was established in the seventies on the site of the present tennis courts and for a time was more or less adequate for hospital needs. Later, additional vegetables had to be procured by contract. The greenhouse was erected in 1930 by Mr R. S. Gibbs at a cost of £450. In 1943 the Board purchased the nursery of Mr A. V. Gibson at the corner of Marshlands and McSaveney's roads. It comprised six acres and had nine glasshouses. Three years later it had produced forty six tons of vegetables for the year. An additional adjoining area of seven acres was secured in 1945. Further market gardening is conducted on spare land at the Teresa Green Home.

It was intended in this history to deal fully with the matter of milk, its purities and impurities. The attempt has been abandoned. If all that has been said and done about milk in Christchurch were recorded it would fill several volumes, the bulk of which would be repetition. The purity of milk was discussed by the B.M.A. seventy years ago and the debate thus started goes on even now. Pasteurised milk is of course used in the Christchurch Hospital. Its use was advocated long before it was adopted. A compromise was effected as early as 1898 when the Board refused pasteurised milk as being too expen-

sive but undertook to supply it to individual cases on a medical requisition. The successful milk contractor to the hospital for many years in the last century was a man who made a reasonable living by the application of science to primary production. His descendants have divulged his method and authorised its publication. It was a simple mathematical formula—one bucket of water to every two buckets of milk.

In 1941 the Board considered plans for an entirely new kitchen to absorb the cafeteria and part of the nurses' old home. But pending the rebuilding of the hospital the scheme was deferred though some improvements were made in 1962.

The hospital can be proud of its kitchen. Meals in an institution are usually the first target of the critic but there are now few complaints about food. The kitchen caters for nearly 600 patients with possibly 150 special diets a day and supplies the cafeteria and the various hospital workers. It is always punctual and effects a minimum of accidents and waste. During the depression the economy campaign reduced the food wastage from 200 lbs. per week to 100 ozs. Its smooth efficiency is controlled by a staff of fourteen women.

THE DISPENSARY

The first dispensary was in a corner of the original hospital just beyond the first ward 1 and ward 2. It was in close proximity to the outpatients' department as, of necessity, it has always had to be. When the first Nurses' Home was built in 1892 it encroached on this site and the old dispensary was demolished. New premises were found nearby in the building where the splint department now is. Here it persisted till 1914 for a time sharing part of its premises with the pathologist. When the new administration block was built and a new outpatients' department became established, the dispensary had to move to the adjoining premises, where it remained until 1961. Naturally enough as the hospital expanded it needed more room. But it is easier to accommodate bottles than bodies and its demands were modest and were met in 1925 by erecting a cellar under the outpatients' department.

In the days of provincial government the dispensary had to supply the gaol, Sunnyside, Burnham and charitable aid. The drugs came first from England and were mainly chemicals in solid form from which liquid prescriptions could be prepared. They varied only in quantity from year to year. The dispensary did not have to contend with the modern persuasions of the manufacturing chemist. The major part of the annual drug order was cotton wool and surgical dressings. From about 1896 the ingredients for medicines were procured locally, the successful tenderers being usually Messrs H. F. Stevens or Kempthorne Prossers. Dressings, however, were still indented direct from England.

During the troubled periods of the hospital in the last century there was always calm in the dispensary. Nothing more dramatic happened than that a bottle fell off a bench or blew its cork. Board members at times would watch the mystery of the evolution of a mixture from the bulk bottles, its secrecy carefully preserved by a curious symbolisation of dog Latin, and would hope that the dispenser was doing only what he was supposed to be doing. They refused in the eighties several applications from men who wanted to become apprentices and learn dispensing. In 1909 they authorised the preparation of the first hospital pharmacopaeia. The last male dispenser was Mr Painter who after 14 years' service resigned in 1912. Miss Gregory was appointed. In 1909 the Auckland Board had written asking for the North Canterbury Board's support in modifying the pending Pharmacy Act to allow nurses to become dispensers. Christchurch did not agree and refused to co-operate. But in 1913 the Board changed its mind. The assistant dispenser was dismissed and instead of a replacement senior nurses in rotation did dispensary duty. It was an unpractical scheme and did not last long. As Dr Scott said: 'It was of no advantage to them or to the dispensary.'

The first war was responsible for an alteration in the method of supply. Dr Scott made large indents on English firms as the local supply was too precarious. The goods were not easy to procure but the hospital received favoured treatment. At one stage it was importing half a ton of cotton wool every six months. The appointment of Miss Gregory created a prece-

dent. Henceforth the dispensary was to be controlled by women. In 1921 the New Zealand Pharmaceutical Society objected forcibly to the employment of women in hospital dispensaries. The Board was unmoved and after a highly successful experiment lasting for fifty years is probably now completely unmovable. Miss Dalley replaced Miss Gregory in 1916. Miss Rogers, who had been assistant for two years, then became dispenser in 1919 and remained till 1925 when she left to get married. Her place was taken by Miss J. M. Laurenson who had been an assistant dispenser in 1914 when the practice of trying to combine nursing with dispensing was abandoned. Miss Laurenson easily established the record length of service in this department. In 1954—forty years later—she retired about the same time as her sister, Miss F. Laurenson, resigned from the position of assistant matron. Her nearest rival was Miss E. M. Keatinge whose departure in 1952 ended a twenty-seven year period as assistant dispenser. The present dispenser, Miss Z. Sawers, followed Miss Laurenson in 1954 having entered the department in 1950.

The dispensary, which has recently acquired the new title of the pharmacy, has grown along with the hospital. It has a staff of eleven with a further two in St Andrews outpatients. It handles all dressings, drugs, X-ray films and surgical instruments. It supplies all the Board's institutions. It has become a training school in pharmacy where at present some male students are taking the four year course. It now makes up over 100,000 prescriptions a year.

Increased responsibilities inevitably demand increased facilities and for some years the pharmacy has been overcrowded. Its chance to expand came in 1960 when ward 5 was cleared of patients. Considerable internal alterations were effected and in 1961 the pharmacy was shifted to its new premises. It is thus back almost on the ground it occupied a century ago. But this area is already marked for complete removal in the coming rebuilding of the hospital. The pharmacy at present is therefore housed in a transit camp.

THE PORTERS

There was one porter when the hospital opened in 1862. Today there are forty-seven (now known as hospital orderlies) and the succession has been unbroken though the duties have changed from time to time. Though the basic duty of the porter has always been that of controlling the internal transport of the hospital it has from time to time included many other tasks. Whenever some new aspect of hospital work arose it was a safe conclusion that it would be given first to a porter, and then if it increased in scope or became more technical in performance, a new post would be created. Sixty years ago the yardman, messenger boy, roustabout, gateman, morgue attendant and mattress maker were all members of the porters' staff. This same staff was at the time responsible for dusting, scrubbing, carrying meals, window cleaning, attending guinea pigs and disinfecting the fever van, as well as the duties it still performs.

The earliest porters' lodge was much more commodious than the present one. It was a two storeyed structure adjoining wards 1 and 2 and was the first building encountered by the visitor entering from Oxford Terrace. It existed on a site approximately where there is now the courtyard of the Board's offices. The porters were then resident and the top floor was for their sleeping accommodation. There was also a small porters' lodge on the street where the gateman lived. A gate at the side of this lodge gave pedestrian entrance to the hospital while the carriage gates were about ten yards further to the west. The duty of the gate porter was to supervise all traffic, examine all leave passes and to apprise the hospital of the arrival of any patient by means of an electric bell. The large gates were closed at dusk and all entry to the hospital after that was through the porters' lodge.

In 1914 this all changed. The administration block was built with a porters' lodge strategically placed almost on the street. The old entrance was shut up and the office of gateman ceased to exist. For a time an attempt was made to close at dusk the vehicular entrance off Riccarton Avenue but as the only purpose of this would be to prevent burglars breaking in and

stealing patients, the custom developed of leaving the gates open. They however are still there though it is doubtful if they have been closed for years. A staunch advocate of the open gates was Dr Fox who had little fear of burglars getting in and would have quite approved of certain patients getting out.

In 1914 the porters worked from 7 a.m. to 7 p.m. seven days of the week with a half day a week off while every second Sunday they worked for the first two hours only. The Board in 1910 had decided that only middle aged men should fill the positions. The position of head porter was created in 1912 and the first appointee was sacked almost immediately for incompetence. There was difficulty in obtaining porters during the first war and in 1919 the Board raised the wages. The head porter was to get £135, the hall porter and night porter £122 and the day porters £104—all with their keep.

As the depression deepened so did applications for positions increase. At one stage the Board advertised for a porter and the advertisement concluded: 'Queue will form from ten o'clock.' But by 1936 the finances of the country were rapidly improving and the porters participated by getting a 44 hour week. This meant that an extra six had to be engaged and there was no accommodation for them. They accordingly had to live out of hospital. Married men had been doing this for some time while the living quarters in the hospital were reserved for single men. The Board was determined that these quarters should be kept full and resolved in 1935 that if any single porter married he would lose his job.

This portion of the hospital service now works very smoothly. Appointments of orderlies are made by the House Manager. The wages and hours of work are covered by an award rate. The duties involve anything that can be done better by porters than by anyone else. The first essential is a good pair of feet. The porters themselves claim that they walk an average of seventeen miles a day. The next essentials are willingness, initiative and adaptability. In certain crises, such as the influenza epidemic in 1918 or Ballantyne's fire in 1947, the efficiency of the hospital depended on the initial competency of the porters.

Though they know more of the hospital than does any other

service, in philosophy they dwell apart. They answer all calls and control their own duties. They make no concessions to history. For decades at a time the Board minutes contain no reference to them. They have not demanded new premises, modern tools or mechanisation. They form the only department of the hospital that has kept its ranks closed against the other sex.

Within the autonomy of their control they have their traditions, their methods and their Caesars. One of these was Mr G. H. Tyler, inevitably known as 'Wat'. He was appointed in 1903 and retired from the position of head porter in 1935. Many will remember his sleek flaxen hair and his energetic stride. He had the vigorous personality that feared no one, with the possible exception of Dr Fox, who in turn could hide no secrets from Tyler. They thus worked for many years in an alerted concord of friendship and respect. The disgruntled citizen who stormed up to the hospital with a complaint needed to have it well based to carry it past Tyler in the lodge and Dr Fox in his office. In the depression when the inebriated, seeking a bed for the night, often arrived with a florid symptomatology Tyler was quite capable of deputising for the casualty officer and at the hospital door showing the patient his choice of routes as he left. He was a superannuitant of the Board. He died in Palmerston North in 1958.

Equally famous on a quieter plane was Mr W. A. Miller. He was a blacksmith who was invalided out of the army in 1915. Shortly after he was approached by a porter who was entitled to a ten day holiday if he could find a substitute. Mr Miller was on his way to shoe racehorses at Timaru but with that spirit of co-operation which has always characterised him he consented. He left forty years later, after being head porter for twenty years. He had earned the profound respect of the whole hospital for his efficiency and his friendly personality. For many years (up to and including 1961) he was the Father Christmas who, at the appropriate time, toured the hospital. When he left there was talk of a presentation. He asked instead for the signatures of all the medical staff. These were appended at the end of a minute of appreciation and those who knew him well wrote more into their signatures than merely their names.

He had two sons on his staff, one of whom—Mr N. G. Miller—succeeded his father and is ably preserving the family tradition. The porters have the freedom of the hospital and all parts are open to them. In 1917 one porter modified this privilege by falling through the skylight of the theatre during an operation by Dr Guthrie. Only the anaesthetised patient was unperturbed. The same man later fell from a ramp into the courtyard. He was recognised as an epileptic but the diagnosis did not prevent a third and fatal fall from a city building. Much of the porters' duties concern the morgue. Dr Fenwick tells of the night watchman of his day who would neglect to lock the morgue door at night and offer the defence 'The folk what's inside can't get out and no folk what's out want to get in'. On a later occasion a new porter, an apprehensive person with a troubled imagination that was inclined to dwell on banshees, leprechauns and lights on the moor, had a strong dislike of any duty in the vicinity of the morgue. One night he and another porter were called to remove a patient who had just died in ward 8. The transport having commenced the more robust one deserted on some pretext. By a different route he repaired to the morgue itself, laid down on one of the tables and covered himself with a sheet. Later he heard timid footsteps approaching and after some delay they crossed the threshold. In the dim light a white draped corpse then slowly rose to a sitting position with a long sustained groan. Terror-stricken, his colleague fled and was never again seen in the hospital.

This section is not a history for there has been no history. But there has certainly been a service and this is a tribute to it.

DOMESTIC STAFF

Less can be said of the domestic staff than of the porters, for the domestic staff has never had any autonomy. It has rather formed a recruiting pool which supplied reserves for other departments. In the seventies and eighties, when the domestics scrubbed floors, polished brass, served meals and lived in the attics above the old wards, they were liable at any moment to be conscripted as laundry workers, nurses, cooks or seam-

stresses. They were also liable to the worse fate of being dismissed for female employment was precious in those days.

Throughout the years the staff has fluctuated. The increased size of the hospital has necessitated more domestics but this has been offset by modern developments. The kitchen, laundry and nursing staff became more clearly defined and the duties of the domestics became restricted. In this century they have been aided by better equipment and labour saving devices. Linoleum began to appear in the wards in 1908 and thereafter there were more mops and less scrubbing brushes.

Such developments as have occurred in the domestic service of the hospital may be classified under the three headings of control, accommodation and duties.

Up till the eighties the Board, fearful of deputing any authority, appointed and discharged the domestics. Then the practice arose of placing all the female staff, including the domestics, under the matron. It was, however, a restricted authority. The matron defined the duties but if she had trouble with any of her domestic staff the Board would want to know the reasons and would constitute itself into a board of judgment. Gradually this practice stopped. From 1909 onwards both the Board and the matron willingly delegated their authority over the domestics. As so many of the domestic staff were concerned with the kitchen and the meals they automatically took orders from Miss Molyneaux. In 1929 there were 48 maids and 12 daily cleaners. When Miss Molyneaux retired in 1934 her assistant, Sister Randall, succeeded. Before long the two positions of dietitian and sister in charge of the domestics were separated. Miss Reid became the dietitian and Sister Randall controlled the maids. She retired in 1943 and received the well deserved thanks of the Board for her twenty-six years of service and for having defined and adequately discharged the duties of a new position. She was followed by Sister A. C. Fleming, who still occupies the post.

The accommodation of the domestics has always been a lesser problem than that of the nurses, but only because of the lesser numbers. When the house surgeons went to the administration block the maids went to the A.D.M.S. As the house surgeons increased in number some had to go back and the

domestics occupied part of the old Nurses' Home. This in turn limited the intake of nurses. The institution of a forty-four hour week in 1936 meant that an extra twenty-six domestics had to be engaged. At last in 1951 the Board bought 'The Lodge', a private hotel at 36 Hereford Street where forty of its domestic staff now live. This provided more space for nurses and from this date it was possible to institute the study day once a week, although it could not have been maintained if fresh provision had not been made for forty-eight probationer nurses, half of them in the hostel in Ensors Road and the other half in the old St Andrew's manse. Despite all this, some nurses and some domestics still live in the old Nurses' Home.

The social evolution which has banished domestics from private families has had its counterpart in hospital life. As a class, domestics have been exploited. They have in the past been poorly paid, overworked, and too often subject to the caprices of a mistress determined to preserve a social distinction. The result has been a social strike and a departure for freer fields in which to labour. During the depression the hospital had no trouble in maintaining its domestic staff for there were hundreds willing. But after the depression the ranks thinned. The work, by tradition, had unpleasant associations. And yet it had to be done. The Board finally had to resort to outside help. An organisation known as Commercial Cleaners Ltd. had effected a pool of domestic workers under conditions that removed many of the previous causes of conflict. It had defined hours, an award rate, liberal leisure, a uniform, and a control that was the impersonal one of an organisation rather than the irritating one of a mistress. It was this organisation that was eventually to secure practically the whole contract for the Board's cleaning and domestic service.

It was built up gradually. In 1942 the commercial cleaners undertook the polishing in wards 9, 10 and 11. Within a few months this was extended to all the wards and the dining room. In 1943 they took over the full cleaning of St Andrew's outpatient department. Gradually the work increased not only in extent but also in scope. By December 1946 they were doing full domestic service (transport and serving of meals) and floor polishing for the whole of the hospital, the Nurses' Home and

the living quarters of the resident staff, medical and non-medical. They also have comparable duties at Burwood and Princess Margaret Hospitals and at the Sanatorium.

CHAPTER TWENTY-SIX

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The Friendly Neighbours

THE BENEFACTORS

UP TILL 1907 THE BOARD COULD NOT LEVY FOR CAPITAL OUTLAY and all bequests were precious especially as they carried a Government subsidy. All subsidies were stopped in 1930. In 1958 the Government took over the financial responsibility for all hospitals. These changes have undoubtedly influenced some testators.

The following list includes not only legacies for the hospital itself but also for the other institutions controlled by the Board. Many wills left bequests to a number of organisations and would be incomprehensible if defined in terms of the hospital alone.

The list is complete only within certain limits. Anonymous donations, contributions to public appeals and periodic grants by special sections of the community are not given. There have also been excluded many legacies of under £100 unless they have some current or special interest. This has been done for reasons of space and not because of any indifference to the story of the widow's mite.

Owing to the changing social pattern some bequests can no longer be applied to the specific objects for which they were intended. Largely owing to the work of Mr A. Prentice these were collected and incorporated in the Amalgamated Trust Fund on which the Board draws from time to time for purposes that are in sympathy with the wishes of the various benefactors.

In what follows a date after a name refers to the year of death. It does not however indicate when the will was drawn

which might have been long previously when different circumstances operated.

F. N. ADAMS (1929). A valuable house and property at Clifton, once estimated to be worth £15,000. Subject to life interests the estate is to be realised and the proceeds are to go to the building of either a new ward or a new operating theatre.

JANE AUSTEN (1953). £1532 for the Nurses' Recreation Fund. This amount represents one-ninth of the net estate.

EMILY BANFIELD (1919). £2006 for endowing an Emily Banfield cot or bed.

WILLIAM JAMES BARKER (1948). The interest on £350 to be spent annually on periodicals for the Jubilee Home.

JAMES BARR (1936). One-fifth of a residuary estate for the general purposes of the Hospital (Amount received £1362).

MAUDE BARRETT (1912). £500 for radium.

ELIZABETH BARNETT (1958). £500 to provide an income of £50 for Christmas comforts at Tuarangi.

GEORGE BENTRAM (1913). £1087 for the general purposes of the Hospital.

ARCHIBALD BINNIE (1930). £300 to the Fresh Air Home to endow a cot in memory of his wife, Anne Detchment Binnie.

M. A. BISHOP (1951). £200 to the H.L.V.A.

JANE JANET CAMERON. House and property at 334 Riccarton Road left to Hospital Board (sold for £600).

ELIZABETH CAMPBELL (1915). £500 for the erection of a chronic ward. This sum was redundant for the purpose when the Chalmers wards were built shortly afterwards and the money is now held in the Amalgamated Trust.

JEAN CHALMERS' BEQUEST. In her lifetime Miss Chalmers provided the Chalmers Wards (see chapter 12). Her will defined some specific bequests including £10,000 for 'The Chalmers Ward Endowment Fund'. The gross estate was over £220,000 and after death duties, specific bequests, etc., the residuary estate was £74,230, one-half of which was bequeathed to the North Canterbury Hospital Board.

JOHN THOMAS CRANE (1954). A residuary beneficiary. £4570 for 'the advancement and benefit of Jubilee Home'.

ARTHUR JOHN CLARKSON (1934). Half of the residuary estate

- to St George's Hospital and the other half (about £579) to the radiotherapy department for apparatus and research.
- W. COLLIER (1893). £130 to the Charitable Aid Board.
- LAURA ADA MABEL COLLIER (1928). £100 for endowing two cots.
- WILLIAM COOKE (1920). The annual interest on £1000 to be applied to the maintenance of the grounds of the Kaikoura Hospital.
- ROSABEL COOPER (1926). Approximately £933 for the Jubilee Home.
- MARY ANN COWAN (1943). An estate of £8150 was left to Trustees to help girls in training. Preference was to be given to nursing trainees or failing such to girls in High Schools or Technical Colleges, provided their fathers had been killed in the war. All applicants had to be protestants.
- HANNAH CRAMP (1924). £479 for the Jubilee Home.
- T. E. CRISP (1927). £250 to the Hospital.
- MISS CUTHBERT (1939). £250 to the H.L.V.A.
- EMILY DALE (1940). £100 for endowing an Emily Dale bed.
- DEANS' BEQUEST. £250 to perpetuate the memory of Lt. Alexander (Alistair) Deans, killed in action in France in 1917. (£200 was used for furnishing the new Nurses' Home).
- M. M. DEARSLEY (Mrs) (1941). £200 for the Children's Ward.
- MARIA JANE DENNISTON (1947). £300 to the Fresh Air Home.
- HENRY STARK DRUMMOND (1905). £100 to the Ashburton Home (later Tuarangi); £200 to the Christchurch Hospital; £1000 to found an inebriates' home. (This last sum is still held by the Public Trustee and the Board gets the annual income).
- WILLIAM DUNLOP (1942). Approximately £282 to the Board.
- DWYER BEQUEST (of Temuka). £500 to the Board. Used for erecting the balcony to ward 8.
- HANNAH MARIA EARLE (1920). Approximately £1700 (subject to life interests) for the maintenance or benefit of poor or destitute patients.
- WILLIAM EASTON (1926). £100 to the Board.
- JAMES EATON. £3184 for the Jubilee Home.
- ELL, JEANNE (1961). £110 to the Jubilee Home.
- ZILLAH FAIRHURST (1918). £1000 to the hospital; £500 to the

- 'Public Benevolent Institution' (The Charitable Aid Board and the Christchurch Benevolent Association both claimed this and the Supreme Court ruling was in favour of the Board); the residue of the estate (£1118) to be divided equally between the Hospital and Dr Barnardo's Home.
- DR P. C. FENWICK (1959). £200 to establish a memorial prize for nurses in senior medicine and diet therapy.
- SAMUEL FLETCHER (1908). Approximately £1400 for the Lyttelton Orphanage.
- ANNIE MURIEL FORRESTER (1960). £200 to the Jubilee Home.
- JAMES FOSTER (1942). £925 for the Jubilee Home.
- JOHN GALE (1936). Approximately £414 to the hospital.
- DORA GILL (1932) (Ex-acting Matron Tuarangi). £100 to Tuarangi.
- JAMES GILLANDERS (1934). This estate which runs into several thousand pounds is, after certain life interests, to be divided between the Board and the N.Z. Cancer Campaign Society.
- FREDERICK ALLEN GREEN (1916). Died in England. The Australasian part of his estate was realised and the proceeds divided among all the hospital beds in New Zealand. The North Canterbury Board received £1133.
- SIR JOHN HALL (1907). A sum of money to the Hospital. (Amount not stated in the records but apparently was considerable as the matter of building a new ward with it was discussed).
- ELI HAMILTON. A trust fund producing an income of approximately £75 a year to be given as a prize annually for a nurse (see chapter 23).
- A. L. B. HARRIS (1932). £530 for the relief of destitute patients.
- SIDNEY B. HARRIS (1916). £100 to hospital; £50 to Jubilee; £50 to Tuarangi.
- DAVID JOHN HATHAWAY (1938). £200 to hospital.
- ELLEN M. HERBERT (1952). £1126—one-quarter share each to Jubilee, Tuarangi, Coronation and the Children's ward to provide additional comforts.
- HENRY F. HERBERT (1943). £100 for the upkeep of two Annie Herbert cots in the Children's ward.
- ALICE EMMA HILL (1946). £170 to hospital.

MRS HOBDAY (1913) (Wife of Col. H. S. Hobday). £500 to the H.L.V.A. for the relief of destitute patients.

GERTRUDE MARY HUGONIN. £200 for improving the hospital buildings.

ARTHUR ARCHIBALD HUSTON (1948). Approximately £4000 for the alleviation of suffering by cancer patients.

F. INNS. Memorial gift of £100 in 1961 towards provision of oak doors for Burwood chapel.

ARTHUR EDWIN JOHNSTON (1944). £191 to the hospital.

JESSIE JONES (1938). £1070 to the hospital.

DAVID LATIMER (1926). £1390 to hospital. (The three other hospitals in the main centres received similar amounts from a residuary estate).

MARY LE PAGE. £500 (to date) for the hospital.

L. LEDWIDGE (1929). £118 for 'the comfort and benefit of nurses'. (Used in the construction of the Nurses' tennis courts).

WILLIAM LEENEY (1929). £100 to hospital.

JAMES LIDSTONE (1944). £107 to hospital.

EMMA E. LOCKE (1938). £492 to hospital; £492 to Jubilee.

HON. CHAS LOUISSON (1924). £100 to H.L.V.A.

THE LUCAS BEQUEST (1879). William Lucas lived at Akaroa.

He owned property there and also in Christchurch and Ashburton. He was illiterate and signed his will with a cross. His wife was of unsound mind for many years before her death. His will left his estate in trust for his wife. After her death all the property 'in the county of Akaroa' was to go to the Church of England. All other property not in the county of Akaroa was to go to the Orphanage Asylum at Lyttelton. After his death it transpired that he had no property in 'the county of Akaroa'. He had three properties totalling twelve acres in the borough of Akaroa which is not in the county. The Charitable Aid Board on behalf of the orphanage therefore claimed this. So did the Church Property Trustees who relied more on the intention of the testator than on the strict letter of the law. Both parties agreed to long term leases while Mrs Lucas was alive. She died in 1905 and the issue between the Board and the Church was settled in the Supreme Court which ruled that the Charitable Aid Board

should succeed. The transfer was made and the title taken on May 13, 1908.

The Board then applied for the Government subsidy of £500, this being at the time the maximum paid on any one bequest. The Government refused on the grounds that the assets were in land and not in money and that no subsidy was applicable. It refused to acknowledge the precedent of the Twigger estate where, though the bequests were in lands and mortgages, three independent subsidies of £500 each had been paid.

The Board thereupon proceeded to sell the property at Shirley and Woolston and so turn the land into money on which it claimed the subsidy of ten shillings in the pound. The Government paid this up to a total of £483 and then refused to pay more. Supported by local legal opinion the Board instituted in 1911 a claim under the Crown Suits Acts. The Solicitor General on behalf of the Government asserted that the Board's petition was statute barred in that the claim arose more than twelve months prior to the institution of the proceedings. The Court upheld this 'highly technical plea' and no more subsidy was paid.

At the time the Board acquired the bequest it was valued at £6393. In 1959 the capital in the bequest was still £7309.

JOHN MAPLES (1943). A property in Waltham Road and a cash bequest which on the expiry of life interests realised a total estate of approximately £5500. For general hospital purposes.

HYMAN MARKS (1895). £5500 to the Marks wards; £5000 to create the second Destitute Patients' Fund. (See chapter ten).

JAMES MAUNSELL (1870). £250 for a hospital ward. (See chapter six).

E. C. MAXWELL (1888). £1000 to the hospital.

A. M. E. MICKLE (1936) (Widow Dr Mickle). One-eighth residue of the estate to the hospital (approximately £1750).

HENRIETTA MICHAEL (1934). A property in Barbadoes Street. Proceeds of realisation to be used for cancer research. (The will was contested by a relative and on legal advice the Board settled for £300).

GEORGE MITCHELL (1930). Two-fifths of an estate (subject to

life interests and not yet realised) to be invested and applied to comforts for Jubilee Home. It is estimated that the proceeds of the bequest will be in excess of £20,000.

CHARLOTTE MORTON (1949). £145 to Tuarangi.

MOULE BEQUEST (1890). Stephen Cole Moule was a farmer near Prebbleton who owned valuable property both in town and country. The year before he died he made a lengthy and involved will. The three main clauses were:

- 1 His wife was to receive all his personal effects and £500 a year.

- 2 His only son was to receive £3 a week—payment to cease immediately in the case of bankruptcy.

- 3 The rest of the income was to go to Tuarangi.

These were simple clauses but some subsidiary ones introduced complications.

- 1 The annual income was to be regarded as a separate bequest each year and was therefore to qualify for an annual Government subsidy of £500.

- 2 The principal property in Cashel and Lichfield streets (then as now occupied by J. Ballantyne and Co.) was not to be sold as long as it brought in an annual rental of not less than £600.

- 3 The original trustees, John W. Overton and Robert McGregor, were to receive £25 a year each for their services (or £50 after the death of Mrs Moule) and could appoint their successors who in turn could appoint theirs and so on for all time.

- 4 The office of trustee could not be held by any member of the staff of the Public Trustee or of the Hospital or by any member of the Hospital Board.

The testator died in 1890 and his wife two years later. Not unnaturally his son, Stephen Cole Moule Jnr, contested the will. The action was brought in 1896. The petitioner claimed that the condition upon which the gift was made infringed the rule against perpetuities and that the condition was illegal and incapable of performance.

The Board defended the action and was successful. The Court did not regard the will as a model one but considered that the conditions were not impossible to perform. The

Board's bill of costs was £244. (The estate at the time was valued at £21,600). The son died in 1900 and the Board thus became heir to the estate. The trustees then made available for the first time a statement of receipts and expenditures. This they had previously refused to do during the life of one of the beneficiaries. The Board had protested but on the advice of Sir Robert Stout had taken no further action.

The first payment of £1000 was made to the Board in 1902 and the Government paid £500 subsidy. When another £1000 was paid the following year the subsidy was refused on the grounds that an annual subsidy could not be paid on an annual income. The trustees thereupon withheld further payments contending that the terms of the will were being infringed.

It was obvious that, despite a previous ruling of the Court the terms of the will were impracticable and that only legislation could break the deadlock. A draft Act was therefore prepared and submitted to Mr Justice Denniston who very carefully considered its terms and took evidence. The provisions of the Act were duly advertised before the session began. It was submitted to committees of both Houses and became law on September 26, 1904.

By this act the trustees were to continue and the annual income was to be paid by them to the Board. The Act also attempted to make some redress for the harsh clause in the original will whereby the late Stephen Cole Moule Jnr had been restricted to £3 a week. He had left a widow and three children. For them a house was purchased, a grant made and an annuity arranged for all four. The children were to receive £2 a week each but on the death of any one his or her share was to continue and to be divided equally among the survivors.

Since then the operations of the Moule bequest have produced much money and a minimum of trouble. The income has fluctuated but even during the depression of the thirties was never less than £800 and sometimes was over £1000. In 1936 Ballantyne's lease was renewed at £1500 a year. Only the land is owned by the Board and the tragic fire of 1947 did not affect the Board's assets.

In 1959 the total value of the estate administered by the trustees was £49,557 and of this amount £23,118 was represented by freehold property, £14,921 by mortgages, £8937 by stock, etc., and the balance was held in the savings bank and current account. The three surviving children still receive their £2 a week each. The income paid to the Board in 1958 was £3097.

FRANCES ANN MACLAY (1959). £1443 to provide patients amenities not available from public funds.

GEORGE H. McCORMICK (1942). £150 to Jubilee Home.

WILLIAM McDOWELL (1931). £6000 for the Wm McDowell Cancer Ward. (The widow contested the will and the Board received £4000).

HON. J. T. PEACOCK (1906). £500 to the H.L.V.A.

ROBERT PEPPERELL (1930). Approximately £3467 to the hospital.

JAMES POWELL (1917). The testator was a retired merchant of Westport who left an estate of £50,000. After many public and private bequests the residue was to be divided between the four main hospital boards of New Zealand. It was not till 1942 that final distribution of the estate was made and in the meanwhile it had gone on increasing in value. The North Canterbury Board received in all £13,900.

L. H. PRICE (1917). £100 to the hospital.

A. A. PUNTER (1932). £400 to the hospital.

FREDERICK EDWARD RAMSAY (1943). £556 to the Sanatorium.

LADY RHODES (1929). £500 to the H.L.V.A.

THOMAS ROUSE (1925). Approximately £509 to Tuarangi.

LAURENCE RYAN (1920). £100 to Tuarangi.

CLAUDE ERNEST WHITE SAWTELL (1917). £2000 for additions to the children's ward.

HELEN SUTHERLAND (1950). £100 to the radium department.

NEIL McNEIL SHAW. £100 to the hospital.

WILLIAM SHERRIS (1957). £500 for comforts for the Sanatorium.

SIR ARTHUR SIMS. £1000 to the hospital; £4000 for radium; £30,000 for the theratron. (See chapter eighteen).

ELLEN SLATER (1945). £1864 for the women's ward (Ward 11).

ADA SMITH (1921). £300 for injured soldiers.

EDITH MARGARET SORENSEN (1940). £250 to the hospital.

THE STARK BEQUEST (1895). £500 to the hospital.

MARY THORPE (1919). £1050 to hospital (mainly used for furnishing the nurses' new home); £50 to Tuarangi.

M. THURSTON; ex-matron (1961). £75 for windows of chapel of Christchurch hospital.

MRS TOWNEND (1914). £1000 for the endowment of the G. H. Moore ward at the Sanatorium; £4000 in mortgages to the H.L.V.A.

THE TWIGGER ESTATE (1885). The foundation of this estate was laid by the Rev. Joseph Twigger, one of the earliest settlers. Little is known of him except what was revealed at his inquest for he left no records and no descendants. He must have been possessed of means for he made heavy land purchases in Christchurch and lived on unearned income. He disappeared on March 21, 1855, and was found drowned in the Avon near the Barbadoes Street bridge two days later. He had last been seen leaving a certain hotel at midnight in a condition which confirmed the well known fact that he was not a teetotaller. The jury brought in a verdict of accidental death and recommended that a railing should be erected between Oxford Terrace and the river. He left no will and presumably no relatives. There were no claimants till 1861 when John Twigger of Rugby, England, advanced evidence that he was a nephew and the next of kin. With his wife he came to New Zealand, proved his claim and succeeded to the estate. He lived at Hillmorten Farm on Lincoln Road until his death in 1885.

His will, made eight months before his death, instructed his trustees to realise on his estate as soon as possible after his death and for this reason they were allowed to rent the property on an annual basis only. After providing for a life interest for his wife the residue of the estate was to go to the United Charitable Aid Board to form a trust, the income from which was to be paid in three equal shares to the Ashburton Old Men's Home, the Female Refuge and the Lyttelton Orphanage.

The estate consisted of a small sum of money in the bank (about £23), a mortgage of £5350 made by the Canterbury

A. and P. Society, 108 acres, freehold, on Lincoln Road and the homestead and contents which were to be for the use of Mrs Twigger during her lifetime. At the time of death the total estate was valued at £16,679.

The trustees were Wm. White, a coal merchant of Addington and Abraham Ashworth, a butcher, of Lincoln Road. There was considerable evidence that they were reluctant trustees. They made no attempt to realise on the estate and the Board did not know it was a beneficiary until a year after the death of the testator. The news came in the form of a letter from the trustees asking if the Board would agree to a reduction of the A. and P. mortgage from 7 to 5 per cent. The Board agreed and waited for the realisation of the estate. But the trustees seemed incapable of taking any active steps and even asked the Board for its advice as to a suitable method of sale. Eventually they intimated that they would be willing to hand over their responsibilities to the Board. The Board put the matter through the Supreme Court and in November 1891, six years after the testator died, the trusteeship was transferred.

The Board then applied for three Government subsidies, each for the maximum of £500, claiming that there were three bequests, one to each institution. The Government said there was one bequest—to the Board only. In the argument that followed dates became important. The will was made on March 26, 1885. The testator died on November 7, 1885. The Charitable Aid Board met for the first time on November 17, 1885. It was not till this last date that the three institutions came under the control of the Board. During the lifetime of the testator they were all separate institutions. The Crown Law Office admitted the validity of this argument and a subsidy of £1500 was paid.

The subsequent history of the estate is complicated. Minor portions from time to time have been sold (including another three acres in 1917 to the A. and P. Association). The major portion has been leased. In 1899 the Metropolitan Trotting Club leased 21 acres. It has steadily acquired more through the years until by 1939 it had secured all that was available (about 93 acres) at an annual rental of £739. In 1943 the

rent was fixed at £1500 a year. In 1946 the Finance Committee recommended a 99 years' lease but the Board, acting on the advice of its solicitor, preferred a 21 years' lease with perpetual right of renewal, the rent to be reviewed every ten years.

The present rental is £2000 per annum. The income from the bequest for the year 1958-1959 was £2246 and this is divided between Tuarangi, Essex Home and the Children's ward at the hospital.

Mrs Twigger died in 1891 just before the transfer of the estate to the Board. She and her husband are buried in the Addington cemetery where the original trustees erected a monument at a cost of £82. As the family was now extinct the Board decided in 1901 to concrete and cement the area and to look after it for all time. A further memorial of course is the naming of Twigger street in Addington.

THE TRAVIS BEQUEST. £700 for radium needles; £200 for medical library.

THE WALKER BEQUEST (1891). £196 to the Nurses' Home.

EMMA WELCH (1934). £240 to the Sanatorium.

SARAH JANE WELLS (1958). £2682 for Coronation Hospital.

MINNIE WHEELER (1951). £1193 for facilities for cancer treatment.

JAMES YOUNG (1921). £2034 to be invested and the interest to provide free beds for the poor.

THE HOSPITAL CHAPLAIN

In 1864 when the Board of Governors were the uneasy guardians of the hospital there was a chaplain who had a room allotted to him known as the chapel. When the Provincial Government resumed control the chaplain was dismissed and the chapel became the servants' dining room. Since then chaplains have been appointed by the denominations they represent and have usually been ministers in a city charge who have included the hospital in their pastoral care. They therefore lacked official recognition by the Board and therefore official record and little is known of them. There is a reference in

1869 to there being no chaplain at the hospital. For part of the eighties the Rev. M. Holland was chaplain. In the nineties the chaplain was the Rev. A. W. Averill (father of Dr L. C. L. Averill and later Church of England Primate of New Zealand). The early Boards, so prone to introduce prohibitive legislation, refused to do so in the matter of religion. Consequently some minor sects, confident that something defined as true religion could be advanced by forcing dissidents to listen to its revelation, moved more and more openly in the wards until they were in effect conducting public ward services. Father Giniarty, representing the Roman Catholic Church, strongly objected to this but the Board refused to intervene. Another protest by Bishop Grimes in 1895 was also rejected but about the same time the findings of the Commission of Enquiry were published and said bluntly that the public ward services must stop. A deputation of the Ministers' Association then waited on the Board and an arrangement was made whereby the Association could use the Board room every alternate Sunday for a voluntary service commencing at 11.15 a.m. This system was maintained until the chapel was opened in 1927.

The first full time chaplain after 1864 was Canon H. Williams, previously vicar of Opawa. He was appointed in 1930, retired in 1954 and died in 1961, being then aged ninety. His tall form, kindly face and purposeful stride soon became well known on the hospital premises. His successor, Canon I. L. Richards, died suddenly two years later and was followed for two years by Archdeacon S. E. Woods. In 1954 the Presbyterian Social Service Association transferred the Rev. Ian B. Wilson from Queen Mary Hospital, Hanmer, to Christchurch. He left for Dunedin seven years later and his successors were the Rev. C. A. Mitchell and the Rev. D. G. Shaw. These chaplains, though full time employees in hospital service, are not confined to Christchurch hospital but also include Princess Margaret, Burwood, Sunnyside and Templeton.

The history of the chaplain inevitably includes the history of the chapels. The chapel in Christchurch hospital, the first real chapel in a New Zealand public hospital, had the effect of demonstrating the sad lack of chapels in other hospitals. As legislation prevents the Board building chapels, Mr A. Prentice

on retiring from the secretaryship of the Board decided to devote his new leisure to raising funds for chapels at Sunnyside, Princess Margaret Hospital and Burwood. The campaign was opened in May 1959. Dedicated and indefatigable Mr Prentice led a team of over 2000 voluntary workers and in six months the objective of £35,000 had been oversubscribed by £1500. (The only public appeals in this history which have been oversubscribed have been this one and the one for the Christchurch hospital chapel.) By 1961 two of the chapels had been opened. Because of uncertain planning, that for Princess Margaret Hospital is still deferred but the money is waiting.

It would have been a memorable campaign had it stopped here but this was the stage at which it really started. By the same methods that were pioneered in Christchurch practically all the public hospitals in the country now have or are getting their chapels. No less than sixteen districts from Whangarei to Invercargill have applied to Mr Prentice for details of his methods. The movement is so strong that the Department, helpful and sympathetic, has laid down a policy directive for Hospital Boards.

THE FRIENDS OF THE HOSPITAL

In 1945 the manpower regulations were lifted and there was an acute shortage of nurses and domestics in hospital. They were barely able to maintain the essential services and would have been quite inadequate in any local or national emergency. Mr Prentice, pondering this, conceived the idea of organising a group of voluntary workers prepared to assist at short notice if the need arose. He approached a Board member, Miss Mary McLean. She approved and referred it to a special meeting of the National Council of Women. The result was the formation of an association known as 'The Friends of the Hospital', with Mrs G. H. Watts as its first president.

This is a vigorous organisation with an apt title. Its members are continually active as opposed to the original plan of waiting for an emergency. They sew and knit, darn and mend, visit patients in hospital and pensioners in their homes. They ar-

range outings and parties. They make toys for the Christmas tree. They staff the crèche where children are left while their parents are visiting in the wards and thus supervise 5000 children a year. They have extended their efforts to Burwood where a special group known as the Burwood Aides operates. They also visit Sunnyside, the Sanatorium and Jubilee Home. They are financed by State subsidy, voluntary donations and members' subscriptions. They are in every respect friends of the hospital. Only the friendly can be friends and this group has now a loyalty to its objectives which has given it some of the attributes of a special club. For approximately fifteen years the president was Miss Mary McLean who, with a background of experience on the National Council of Women and on the City Council, has added her special knowledge of the hospital gained as an early member of the physiotherapy staff and as a later Board member. In 1962 Mrs Hammett, the only remaining foundation member, became the new president.

THE HOSPITAL LADY VISITORS' ASSOCIATION

Through all the history of mankind the compassionate have always visited the sick. It is certain that such good offices must have been performed from the earliest days in the Christchurch hospital but there is no record of them until 1882 by which time Mrs Tom Acland, mother of Sir Hugh Acland, had established herself as a regular weekly visitor. She had also established a tradition which, when ill health beset her, she handed on to Miss Maude who in turn enlisted the Misses Edith and Amy Rhodes and the Misses Edith and Adeline Turner. They were joined by others and in 1887 it was decided to co-ordinate their efforts by forming a Hospital Lady Visitors' Association (H.L.V.A.) A meeting was called at which 78 were present. An executive was elected with Mrs Banks as chairwoman and Miss Adeline Turner as secretary. In the rules of the Association their aims and objects were simply defined by the fine charter—'To bring brightness into the lives of patients while

in hospital and to give temporary assistance to the needy when they leave'.

Ever since in a multiplicity of ways this ideal has been realised. Members of the Association have visited patients regularly, outfitted them with clothing, footwear, artificial limbs, distributed tobacco and blankets, given monetary assistance to the needy, provided Christmas parties, established a library, paid the accommodation of men looking for work, bought invalid chairs, supported a large number of patients at the Rhodes Home and the Cholmondeley Home and supplied the matron with regular funds for emergency use. They collected £2066 for the chronic ward fund and when the gift of £8000 from Miss Chalmers made this superfluous the interest went to the chapel fund and the capital to the building of ward 11.

Book cases with full shelves were erected in wards 5 and 6 in 1890 as a memorial to Mrs Tom Acland and the library activities still continue. In 1894 the Winter Work Party, dedicated to making warm clothing, held its first meeting. Concerts in the corridor and sometimes in the wards were commenced in 1890 and continued for over thirty years.

A major activity was the supervision of a patient's convalescence which often took the form of a week at the Rhodes Home, the Association paying the fees (15/- a week up to 1918). In 1919 the convalescence of nurses was also considered. They were overworked, often sick and too poor to pay the fare to their homes. Following the suggestion of Miss Turner, a cottage for the convalescence of sick nurses was purchased at Sumner. The capital cost and also funds for its furnishings were secured through the goodwill of the Association, the Board, the public and the retailers. It is known as the Adeline Turner cottage as a tribute to one who retired in 1930, the sole surviving member of the Association founded 43 years previously.

Occupational therapy was first introduced in 1920, the Association paying for an instructor to supervise long term patients. The first was Mrs Templar, then Miss Bartrum in 1927, Miss Lance in 1936 and Sister Murgatroyd in 1941, for whom premises were found for the first time in the recently vacated bakery. This was a recognition by the Board of the value of this pion-

eer work and since then full responsibility for all costs, maintenance and control has been taken over by the Board.

The Association was also responsible for what might be described as a take-over bid. The first Destitute Patients Fund with similar objectives to those of the H.L.V.A. was started by the doctors in 1879. In order to get the subsidy it had to be handed to the Board and then handed back. Tensions between Board and staff often made this a touchy procedure. When the Association was formed Dr Symes on behalf of the controllers of the fund asked if the H.L.V.A. would undertake the spending. This was agreed to and for some years all parties were satisfied. But in 1894 in the most troubled period of the hospital's history it became impossible to maintain the fund. It was closed and the balance (£28) handed to the H.L.V.A.

The following year Hyman Marks gave his £5000 for poor and needy patients. The money was to be invested and the interest only used for patients. The old title was revived and the second Destitute Patients Fund was formed. Again the H.L.V.A. was asked by the trustees to undertake the distribution for a trial period. The results were satisfactory, the arrangement was confirmed and still persists.

Such activities required money, large sums of money. At the beginning they had only their annual membership fee of five shillings, a few donations from the public and the proceeds of an annual theatrical performance by the Hunt Club Amateurs. Later they regularly held fêtes and garden parties which were extraordinarily successful and resulted in profits always over £500 and sometimes over £1000. This is less surprising if the technique is considered. In the balance sheet of one such fête is the ingenuous item—'Surprise packets. Receipts £348. Expenses £33'.

But such sources are precarious and the persistence of the work has been possible only through some generous bequests. They have gone to the Association (H.L.V.A.) or the Destitute Patients' Fund (D.P.F) or the Chronic Ward Fund (C.W.F.). The main ones have been:

1895	Hyman Marks	£5000	D.P.F.
1906	Hon. J. T. Peacock	£500	D.P.F.
1913	Miss Campbell	£500	C.W.F.
1913	Mrs Hobday	£500	D.P.F.
1914	Mrs Townend	£4000	H.L.V.A.
1920	H. Warner	£60	H.L.V.A.
1924	Hon. Chas. Louisson	£100	D.P.F.
1929	Lady Rhodes	£500	H.L.V.A.
1939	Miss Cuthbert	£250	H.L.V.A.
1951	Miss M. A. Bishop	£200	H.L.V.A.

Most of this is invested and held by trustees and the interest is at the disposal of the Association. This is a wise provision. A nice balance is thereby preserved between the men who conserve and the women who spend. In the Association's minute book is one revealing reference. 'There have been many cases of hardship lately. . . . It was decided to take £100 from capital and regard it as income . . .'

The Association now has its suburban branches. In addition to regular visiting in many of the Board's institutions, organised groups now work at the Sanatorium, at Sunnyside and even in the Chatham Islands. During the war the sewing group sent cases of clothing to similar organisations in bombed out areas in Britain.

The various Presidents and the approximate dates of their appointments are:

1884	Mrs Banks	1930	Mrs Hogg
1890	Mrs Julius	1939	Miss Cardale
1918	Lady Rhodes	1954	Mrs F. E. Wait
1930	Miss Tabart		

When Miss Cardale retired in 1954 she had equalled Miss Adeline Turner's record of 43 years of active service.

The H.L.V.A. is one of the brightest flowers in the social garden of Canterbury. It has never been involved in feuds, has never had to defend itself against criticism, has never prejudiced the respect and admiration it has inspired in the community. The good that the members have done in providing happiness or comfort or even in alleviating misery can be

imagined but can never be assessed in quantitative terms. Periodically the Board thanks them and does so confidently in the name of the public.

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The Outpost of a Centenary

THE YEARS SINCE THE WAR HAVE REPRESENTED THE MATURITY of the hospital and are the most dynamic of its history. It has functioned at its highest efficiency, incorporated all the newest advances in medicine and performed miracles in the consolidation of its bed state. It carries the weight more easily now for it at last is flanked by its lusty apprentices at Burwood and Cashmere. It is itself on the surgical waiting list for the part between the Chalmers and the Marks wards is to be extirpated and the implant made of a new hospital.

But not yet. In the last two decades the furrows of age have been smoothed out and, by much effort, minor but multiple, the dignity has been maintained and the vitality increased.

For instance, Chalmers wards now have modern approaches and new lifts (1956). The social welfare department has its own offices at the end of the corridor (1957). The visitors' new waiting room is light, spacious and airy and the post graduate committee can now creep in quietly and close the door softly (1956). Ward 5 is now the pharmacy (1961) and ward 14, for a time unrecognisable as a ward in that it was vacant, will probably become a Medical Centre. The old patched linoleum of the corridor has yielded to rubber (1949). A post office in the long corridor has replaced the post box in the short corridor. Wards 12 and 13 have doubled in size and, because of their small rooms, more than doubled in usefulness (1942). Ward 11 has ceased to be the gynaecological ward and has become the urological unit (1961). The electrocardiographic unit has been extended. Adjoining is the photographic unit (1946) which began with humble black and white negatives

and now has perfected a high standard of coloured micro-photography.

A new and broad entrance to wards 7 and 8 opening off the main corridor was effected in 1957 and a new lift was installed for ward 8. This was the result of a policy decision to reserve these wards for surgical cases, owing to their proximity to the theatres.

The theatres are now presumably stable in their present location after trailing round the hospital for a century. It has been told how the first one was an insignificant room in the back portion of the old hospital. Then in 1886 was built the next theatre—the glass roofed structure opening off the old corridor between wards 5 and 6 and now part of the physiotherapy department. A new theatre was built in 1902 on the other side of ward 6 and is now part of the radiotherapy department. It existed for twenty years and in it the present age of surgery had its origins. It was in this setting that the reputations were established of such men as Dr Acland, Dr Fox, Dr Sandston and Dr Foster. But it had one fault—it was too small.

During the first war a new theatre was approved. In 1919 a subcommittee representing the Board, the staff and the architect, drew up plans which the Board accepted—after trying unsuccessfully to get the Defence Department to bear some of the cost. The Health Department however did not agree. It said consideration should be given not solely to a new theatre but to something that could later be part of a homogeneous theatre block. The Board then decided on two theatres, to be built further along the corridor opposite ward 9 (the present site). They were opened in 1922 and were stated to be the finest in New Zealand. Like the previous theatre they functioned for twenty years and again in war time were found to be inadequate.

In 1947 there began an ambitious programme of adding two more theatres and modernising the whole block. This was done at a cost of £38,278 and the four theatres were opened in 1948. They have since been air conditioned, provided with a recovery room and a sterilisation room. They are worthy of having the surgical wards in close proximity. This determined the new approaches to wards 7 and 8.

But the deeper changes in the hospital are to be found in the wards and cannot be sensed from the corridor. The patients are different. They are more mellow, more knowledgeable and more appreciative. They are older. They represent an enormous profusion of the degenerative diseases—the failing hearts, arteries and kidneys. Dying, like living, is now prolonged and because of this the 12 patients per 1000 of the population in 1894 have now increased to 102. They are nursed in better wards which are now lighter, brighter with paint, airier with the banishing of the old ward clutter to nearby treatment rooms. Bed linen and sometimes beds themselves have changed drabness for colour. Curtains on fibre track runners surround the beds. This experiment was first tried in ward 15 in 1952 and is perhaps the sole star in the humble crown of this ward. Previously the privacy of the patient depended on the transport of heavy wooden screens, cumbersome, inadequate and inclined to instability. Often enough what should have been hidden was suddenly revealed to everyone in the ward except the patient in the next bed on whom the screen had fallen.

The old corridor has now lost all its glory. The departments on one side have small suburban branches on the other and there is now more traffic across the corridor than along it. The short corridor leading to the main entrance underwent major changes in 1958. This was the final stage of a complete administrative reorganisation initiated perhaps unwittingly by Dr Morton who is a gardener of the type that welcomes the challenge of the forest primeval. He rejected his official residence where he could have controlled the garden without leaving the street and the Board bought him a small house with large grounds in Riccarton—part of the Deans brothers' original farm. The vacated premises, after housing some relays of registrars, became the new offices of the Board. A new brick front was constructed, a modern fence erected and a courtyard established. This reversion to the old original approach has greatly improved the outside appearance and has revealed the imposing solidity of the Chalmers block. The interior was extensively remodelled and included a spacious and comfortable Board room. The old offices were like a

public highway where the staff had no room to spread work and the Chairman had to be content with a desk in the Secretary's office. The new offices are at last the promised land for the Board after twice forty years of wandering in the wildernesses of the splint department, the city council offices, the Armagh Street Depot, the blood transfusion premises and the library.

As the old Board offices were vacated the carpenters moved in and after them the interior decorators. They made an extraordinary transformation in a building forty five years old. When completed, new offices existed for the medical superintendent, the lady superintendent, the assistant lady superintendents, the medico-social workers and the necessary secretaries. Among those who were transferred was Miss Willcox, whose quiet efficiency as secretary to the medical superintendent has smoothed out many a rough administrative patch in the last twenty five years.

Although the medico-social workers were given an office for the first time, they had, long before, established themselves as an integral part of the hospital services. They had in fact inherited a long tradition. In 1915 the Board subsidised the Nurse Maude District Nursing Association by £100 provided the Association continued nursing patients discharged from hospital before convalescence was completed. This system still persists and was extended when Miss Corkill, superintendent of the Association, visited the hospital twice a week investigating the pending discharges. A later problem however was not to provide nursing for such cases but to find accommodation. The appointment of an almoner who could serve as a link between the hospital and the home was first discussed by the Board in 1935. Its strongest advocate was Mrs J. Mackay, who emphasised the need in 1937 and was still emphasising it in 1948. In 1952 the Board appointed the first almoner (or medico-social worker), Miss Simpson. Later Miss Tait became an assistant and still later Miss Rawston. At present approval has been given for the appointment of a fourth member.

Comment on the work of this group can be only in terms of praise. Quite apart from the high personal merits of the first three appointees, the work done is invaluable to a crowded

hospital. Once, the patient ready for discharge had to wait on the slow bestirrings of relatives and the imperfect exploring of available accommodation. Now all the resources, vacancies and costs are known and the delay is minimal. The whole discharge system has been speeded up and it has been estimated that the efforts of the medico-social workers have been equivalent to the creation of a new twenty-bed ward.

The migration across the courtyard from the hospital to the old offices of the Board left vacancies in the short corridor. The telephone box was expanded to a telephone bureau with an increased staff to deal with all inside and outside phones. (The head telephonist, Miss W. Allington, retired in 1954 after thirty years of service.) The lady superintendent's office became occupied by the medical secretaries. The medical superintendent's small room was changed to the admitting office and the last in the row, next the entrance, was reserved for the surgical secretaries. The admitting office was an innovation. Previously, the nurse in the ward entered on the appropriate form the essential details of each new case. It was a method that had little to commend it in terms of nursing ability, convenience of relatives or accuracy of records.

This regrouping of administrative sections had certain consequences. The new Board offices meant that some of the residential staff were dispossessed. The Board has therefore in the last decade acquired considerable living quarters for its medical and nursing staff in the vicinity of the hospital. The most important of these is 'Ranui' on the corner of Cashel street and Rolleston avenue where ten house surgeons reside.

When the Board's old premises were vacated in favour of the internal administrative heads it was no longer necessary nor even desirable that the public should have access from the street. The logical approach was now from the courtyard. The entrance from Riccarton avenue was therefore bricked up and mortar laid on the worn stone steps where for forty-five years thousands had ascended to pay their fees, receive their wages, submit their tenders, sign their contracts, attend (in the depression) their outpatient clinic, register their complaints, receive their reassurances, apply for their rations and, in short, explore and exploit all the resources of the Board.

But of all the changes in the last twenty years the most noticeable is the relative calm in the old outpatients' department.

The house surgeon of the present day is conditioned to working in congested areas and feels he is unfortunate in his generation and that from the point of view of breathing space sooner or later would have been better than now. He should have talked to a casualty officer in the late thirties.

The outpatients' waiting room was then the broad highway to the hospital. All admissions, emergency or arranged, came through it. Minor surgical cases arrived for their sutures or their daily dressings. Difficult problems of diagnosis already under investigation by outside specialists elected to obtain a surreptitious hospital opinion. The patient with a chronic ailment refused to believe that no therapy was possible. Orthopaedic cases arrived in a steady stream and had to be diverted. So did special lesions of ear, eye, nose and throat. Many who came did so not because of the hope of better treatment but because it was cheap. With the patients came the relatives, the ambulance officials, the police, the mates of the man with an industrial injury. Outpatients became as public as a railway station. Often the whole area was packed with compressed groups on the long forms while harassed casualty officers slowly disposed of them one by one. Due to the confusion of arrival there could be no organisation afterwards. The patient waited; the aggressive one was detached, treated and departed.

From the first year the hospital was built there have been complaints of the Outpatient service. The medical officer in charge complained that there were too many patients. The patients complained of slow service. The outside doctor complained that the wealthy were attending. Many attempts at reform were made but the public cannot be held to local by-laws and any improvement was only temporary. In 1930 the Board was prepared to engage a senior casualty officer at £500 a year. Dr Fox opposed this. Better officers might do better work but they would not do it any faster. Then in 1941 came the final insult. Outpatients became free. Partly because of this and partly because private doctors were so rare during the war, still more soldiers and civilians began to crush into the

outpatient department. The Board realised that the department would have to be extended. This could not be done on the present site, nor in fact anywhere on hospital property.

Across the road was St Andrews Church, the mother Presbyterian Church of Canterbury. It existed on a site that had been given by the provincial council in 1854, a triangular island bounded by Oxford terrace, Riccarton avenue and Antigua street. (If this gift had not eventuated the church would probably have been built on the site of the Limes hospital, this area being then for sale for £20.)

A hundred years later the church owned some valuable property on the other side of Riccarton avenue, stretching from Hagley avenue to Antigua street. First there was the manse, a solid brick, two-storied dwelling. Some distance further along Riccarton avenue were the Bible Class rooms and nearby at the junction of Riccarton avenue and Antigua street was the Sunday School. Round the corner in Antigua street was a kindergarten.

At the time the membership of the church had dropped owing to the inroads of industry and the manse was empty. By a majority of one vote the congregation decided to sell the manse and three quarters of an acre to the Government for a St Helens hospital. The Government bought but did not build. The manse was made over temporarily to the Board for soldiers from Burnham and eventually in 1943 was sold to the Board for £8000. About the same time the Board bought the Bible Class and Sunday School buildings for £5000 and in 1950 bought further land in St Asaph street next the laundry.

The policy of the Board was to use all this area for outpatients, laundry, boiler house and bulk store. The first was the specialists' outpatients. The Bible Class rooms were extended and the new outpatients' department opened on July 10, 1944 with Sister Simpson in charge. The Sunday School was leased back to the church for five years. The lease expired in 1948. The church, by now rejuvenated with a new minister and a new manse, wanted to buy the Sunday School back. The Board realising that outpatients would have to be extended did not even want to renew the lease and was in a position where it could drive a hard bargain. But each party had respect for

the objectives of the other and the issue was finally decided in a spirit of co-operation and compromise. In 1950 the Board handed back the Sunday School and received in exchange the kindergarten next door and £2000 in compensation. The church extended the Sunday School and built a lecture room on the top floor for hospital purposes. For this the Board pays £200 a year and in turn sublets it to the B.M.A., A.A., and other groups requiring a comfortable meeting hall.

In 1950 the Board decided that the outpatient facilities at St Andrews were quite inadequate. Plans for extension were drawn by Messrs Manson, Seward and Stanton. The building was erected by Messrs John Calder Ltd at a cost of £45,000 and was opened in June 1952 with Sister Finn in charge of the patients and Mr Mullins to control the administration.

This allowed the old outpatient premises in the hospital to become both in name and in purpose the casualty department. From the emergency point of view this is the very core of the hospital and its efficiency must never be imperilled. In 1961 it absorbed the premises recently occupied by the pharmacy. The whole is to be organised as a ward known as the emergency and accident ward with a resuscitation centre and some holding beds. A surgeon, preferably with experience in chest surgery, will be in charge. In 1960 a new post of Director of Outpatient Services was created and was filled by Dr W. I. Paterson, former deputy medical officer of health for Canterbury.

Since the war there have been many changes in personnel. Among the doctors the last contemporary of Dr Fox will probably retire in 1962. Dr A. Nelson who followed Dr Fox remained till 1952 and was then appointed to Burwood. He had been a worthy successor to Dr Fox. Despite the war and all its difficulties he had met problem by problem and nothing befell by neglect. He had not the urge and restlessness of Dr Fox and at times was prepared to wave an olive branch in circumstances where Dr Fox would have blown a blast on a trumpet. Dr Fox shaped the hospital which Dr Nelson inherited. Each was the right man for his day. Dr Nelson had marked persuasive ability in procuring Board approval for his many suggestions. He never made a dramatic emotional appeal. Instead he

kept up a steady pressure over a period of time and the Board often became convinced without being aware of the mechanism employed. Dr Nelson, now alternating leisure with locums, often appears at hospital meetings, watching with a benign eye over the later scene.

There were seven applications for his post. These were short-listed to three and Dr T. Morton was appointed. Dr Morton had come on the staff in 1949 as assistant superintendent. He had graduated at St Thomas's and had held many important posts in England, including registrar to Sir Maurice Cassidy, and chief medical officer to the London transport executive. In addition to high ability in clinical medicine and administration, Dr Morton has a philosophical bias and can often see to the heart of a problem by considering its motivation. He does not dwell remote and has the happy faculty of dispensing friendliness without forfeiting respect. His instinct is to lead rather than drive. It is a good policy while it works and so far it has.

The lady superintendent, Miss Widdowson, who had been appointed at the same time as Dr Nelson, resigned at the same time. She also had had to cope with all the difficulties of the war and particularly the shortage of nurses. Her work was ably done and she was recognised as one who had in the deepest measure a care for the welfare of the hospital. Among the tokens of esteem when she left was a presentation from the medical staff.

For her last three weeks in hospital Miss Widdowson was associated with her successor, Mrs M. Chambers. The latter was a graduate of the Christchurch hospital, where from student she had risen to tutor sister and had then gained a bursary and gone to the post graduate school in Wellington. From 1948 to 1952 she had been matron of Oamaru hospital. Since her appointment she has shown an ability and personality which give promise that her career will at least be as distinguished as that of the best of her predecessors.

During the post-war periods there were not only new appointments on the Board's administrative staff but the staff was reorganised in 1947. Mr Prentice was secretary and Mr D. Horne was appointed to the new post of assistant secretary.

Mr W. W. Gudgeon remained as treasurer and accountant. Mr J. G. Laurenson was staff clerk and the new position of chief clerk was given to a senior member, Mr A. T. Dalley. In 1950 Mr Gudgeon died after thirty one years as treasurer. Mr Laurenson replaced him. In 1954 Mr Dalley retired with a fine record of forty years in the Board's service. By a coincidence of name but not of relationship Miss L. M. Dalley retired in 1949 after having worked as a clerk in the same office for thirty years. Miss Dalley was one of the very loyal friends of the hospital. During the war she instituted the sixpence a week levy from staff members for the purpose of despatching food parcels to other staff members overseas. She undertook all the organisation including the purchase, packing and posting. She also sent regularly a letter to staff members who were prisoners of war. She was killed in a car accident on Christmas Day, 1960.

As secretary Mr Prentice had a harder task than any predecessor but adequately met all demands. He had a resourceful memory, a sense of loyalty and in the later schisms of the Board an official neutrality. He did considerable research on the early hospital bequests and formed the amalgamated trust fund. He retired in 1956 with the goodwill of everyone with whom he had been associated. His interest in the hospital continued and was crowned with the splendid success of the public appeal for chapels at the three hospitals. Mr Laurenson became the new secretary. Mr Horne retained the position of assistant secretary. Though the secretaries are still young they are experienced officers of the Board, energetic and full of enterprise. A valuable contribution was made by Mr Horne in 1956 when the Board sent him to study hospital administration in Australia. In 1961 Mr Laurenson was awarded a WHO fellowship for travel and study overseas. This was the first such fellowship to be awarded in New Zealand to a hospital officer or to anyone outside the central government.

It would be possible to write at length on the later hospital boards but the temptation is easily and justifiably resisted. When the new Board took over in 1947 it was faced with expanding hospital services and a shortage of staff, especially nurses. It had to deal with the new laundry, the nurses' home

at Burwood, the problems of plastic surgery, the new boiler house, the shortage of maternity beds and, over all, the enormous decision whether to build at Cashmere or to rebuild at Christchurch. It and subsequent Boards disposed of these but there was nothing smooth about the process. Party politics obscured communal interests. Board meetings became unruly. A minority used the privilege of membership for personalities and recriminations and the real progress that was made by the majority was hidden from the public by the noisy truculence of the few. The early Boards were afflicted by the clamour of the staff; the later staff was afflicted by the clamour of the Boards. Mr V. C. Lawn was chairman. His influence was placatory and the hospital was perhaps fortunate that his personality lacked that aggressiveness which might have turned a flame into a conflagration. This unhappy period is now past and is best forgotten. Its detail can be found in the daily newspapers some of which avidly seized on all the items of discord. Historically it is tempting to regard it as the death struggle of party politics in social services.

This doleful decade passed with an extraordinarily swift transition when the new Board with Dr Averill as chairman was constituted in 1956. In extending Christmas greetings in 1958 to Board members Dr Averill commented: 'I must say I am proud that the Board is not now expected to provide the comic strip in the newspapers.'

The last election of 1959 had special features. The Hospital Act of 1957 had limited the size of the Board to fourteen members—seven from the city and seven from the country. The election reflected the political trend at the time and Labour failed to gain any seats though the two stalwarts of the Labour party, Miss Howard and Mrs Teresa Green, did not stand. Two new members were prominent ex-members of the Board's staff, Mr L. A. Bennett and Dr I. C. Macintyre. (The absence of Mrs Green from the Board marked the end of an extraordinary career of selfless social service. For 30 years she had been chairwoman of the Benevolent committee. During that time she had for long periods, as in the depression, given daily service to the hospital, had attended over 2000 meetings, had interviewed many thousands of applicants and through her

wise, kindly, but fearless judgment had earned the deep esteem of the citizens of Christchurch.)

Special problems confronted the new Board. It now had to control three major hospitals and it had to plan for the future. The old Hospital committee was replaced by the Institutions committee which received reports from three subsidiary committees—one for each hospital, the Sanatorium being included with Princess Margaret. The Finance committee of course was unchanged and the Works committee replaced the old Building committee.

This is the present Board. The evidence mounts month by month that it is harmonious, loyal to the strong leadership of Dr Averill, hardworking and courageous in its planning. Its policy for the future has been boldly announced and no one as yet has challenged it. It is most fitting that it should be the Board to plan the centennial celebrations.

As society becomes more complex, administrative control becomes more rigid and the members of the present medical staff passively accept an authority which their predecessors resisted. They work in the hospital to which they are sent, their salaries are declared and not negotiated; the medical staff executive has become the medical advisory committee; the departments of medicine and surgery have their respective directors; the combined hospital staff has replaced the fragments of the full time and the visiting staffs.

Doctors have a horror of loss of freedom. But the past doctor often confused freedom of action with freedom of thought. Specialisation itself implies some concession to freedom of action, but there is no limitation on freedom of thought. The medical staff now has a streamlined organisation whereby its representations can go to the Board or the Department or to other hospitals and have such regarded, not as a peevish complaint but as an honest contribution to progress. All through the hospital history the Board and staff should have had the common objective of the welfare of the patient. It is only recently that the climate of cordiality and the smoothness of the machinery has made this possible. The old conflicts of say 1878 when Dr Turnbull and his militant band defied the Board are at last being resolved not according to the rights

of the individual but according to the rights of the issue involved.

An illustration of this is the treatment of spinal injuries. They are difficult and require special accommodation and facilities. Some surgeons, prominent among whom was Mr W. L. F. Utley, considered these should be provided. They convinced the staff of this and the matter went through the medical advisory committee and the hospital committee to the Board which agreed. The Department was not convinced and a deputation (Dr Averill, Mr L. A. Bennett, Mr Utley and Mr Dickson) went to Wellington. The Department reversed its decision and a spinal injury unit is now being established at Princess Margaret hospital. It was an achievement devoid of militant overtones.

There now exists in New Zealand a Visiting Staff's Association (1958). It was originally proposed by Mr J. Leslie Will. He persisted in his efforts for years, reiterated the arguments, refused to accept defeat and eventually changed apathy to enthusiasm. After his retirement, with his objective nearly in sight, the work was taken over by Mr J. K. Davidson and successfully concluded.

Paradoxically, at the time already noted, when the Board was divided and in the discord of its division spread tension and unrest among the medical, nursing and administrative staffs, at this time then the hospital experienced the happiest day of its history. This was on the occasion of the official visit of Her Majesty the Queen and His Royal Highness the Duke of Edinburgh on January 19, 1954.

Long planning had preceded the event. A strict drill had been imposed on all members of the staff and most of the patients, and typed instructions had been issued to everybody. The whole visit had even been rehearsed in order to study timing, with members of the administrative staff deputising for the principals. The organisation was extremely good and credit goes to the Board's office staff, especially the secretary, Mr Prentice.

At the hospital entrance Her Majesty and His Royal Highness were met by the Prime Minister (Mr S. G. Holland), who presented Mr Lawn, chairman of the Board. Inside the hos-

pital, opposite the casualty department, Mr Lawn presented Board members and their wives or husbands and also the medical superintendent (Dr T. Morton), the chairman of the visiting staff (Mr J. K. Davidson) and the chairman of the combined staff (Mr D. G. Radcliffe). The rest of this short corridor was lined by members of the medical staff and the long corridor by nurses. Conducted by Mr Lawn and Dr Morton, Her Majesty and His Royal Highness went as far as the chapel. The Queen entered the chapel with the hospital chaplain, Canon Williams, where her father, King George VI, had laid the foundation stone. Wards 9, 10, 6, 5 and 4 were inspected in turn. After leaving ward 4, the Royal visitors walked along the drive in front of the hospital to the corner near the nurses' home. The route was lined by more than two thousand people—patients, staff and specially invited guests. It was a triumphant procession and also a triumph of organisation that had even anticipated the Queen's conversations with groups of patients and the unpredictable informality of the Duke. The weather was perfect, the flags were moving, the flowers were profuse, and the scene was of the gayest and happiest. Before the Royal visitors departed they were presented by Mr Lawn with an edition de luxe of a specially prepared history of the hospital. The sixteen pages of text were prepared by Mr Prentice, Dr Morton and the present writer, while the magnificent photographs included were mainly the work of Mr Pope, the senior member of the photographic unit. The book was splendidly produced by the Caxton Press. Of the three copies printed, one—autographed by the Queen and the Duke—is now held in the nurses' library.

It was a memorable occasion, in all ways unique. As the cars left, the rope barriers yielded and added to the confusion of people, thronged on the grounds, framed in all the windows and grouped on the balconies of all accessible wards, cheering and farewelling. The excitement persisted after the visit had terminated. The work of the hospital was resumed but it was less intense than usual. An enormous therapeutic effect had already been produced by the Royal visit.

It is now necessary in this final phase of this final chapter of the history of the hospital to examine the control. This, after

all, is probably the aspect which offers the most marked contrast between 1862 and 1962. Formerly it was effected by personal arrangements between the house surgeon and the provincial secretary. Now it has a vast administrative organisation controlling a multitude of activities in many scattered places and presenting the largest annual budget in the province.

The budget and its sources has been the one constant contentious problem that throughout the years has stood between the hospital and the community. In 1885 levies on rateable property seemed a reasonable enough form of taxation since those without property were usually without means. But from the outset the contributory bodies have resisted the autocracy of a Board which can name the price and send the bill to the taxpayers.

As the rates have risen throughout the years the resistance has hardened. Eventually it became apparent that hospitals, ever expanding and becoming more costly, could no longer subsist on the thin diet of local rates. In 1951 therefore the Government decided to reduce the annual levy by a halfpenny in the pound each year until the levy was abolished. Thereafter the hospitals would depend entirely on Government sources.

It was an enormous decision, the significance of which was not recognised by all at the time. Ratepayers naturally approved of the monetary concessions. Boards approved of the easing of tensions with the local bodies. It was a tame death, this of hospital rating, after its stormy life of seventy years. There was no reference in the funeral oration to the angry meetings of protest by the local bodies; to the defence of policy by Board chairmen, to the pressures and the resistances, to the late payments and the court actions, to the wild charges of extravagances and the counter charges of parsimony. Hospital rating had filled its role in social history when nothing could have replaced it but it died unwept, almost unhonoured and quite unsung.

But there was buried with it a vast quantum of local administrative freedom. By abolishing the rates the Government bought all the public hospitals of New Zealand. There was no legal transfer of ownership. The moral right of the State to

control was irrefutably guaranteed by its acceptance of an annual bill of over £20,000,000.

But the Boards persist, deeprooted in the democracy they represent. This history has been critical of some Boards but the criticism is tossed high in the scales when weighted against the enormous efforts the Boards have made in the care and nurture of the hospitals. Some 210 members of the North Canterbury Hospital Board have controlled it through a century. They have usually been persons of considerable ability in their specific vocations. Their time and their talents have been freely given and their only ostensible reward has been a public trial every three years before the electors. They share with the doctors the long tradition of honorary service to the sick.

There would be no profit in discussing at tedious length the enormous effort that has, through meetings of the Board and its committees and through meetings of the medical staff, concentrated on the perfection of hospital control. Much of the effort has been ineffective in that legislation can never safeguard all the complexities of a large hospital. The complexities are vast. On a few acres where over a thousand people live and many die; where 12,000 sick people are admitted every year and 120,000 attend as outpatients, the whole staff—medical, nursing, ancillary, administrative and domestic—are integrated into co-ordinating groups, all units in a team and each with a schedule of duties that can never be exactly defined. The attempt at definition is made by the bylaws, those curious survivals of the militant era of industrialism. They were first drawn up in 1864 and though in some respects were inoperable, persisted till 1886 when they were replaced by a new edition. After drastic revision in 1891 and 1896 they continued till 1932 when once more they were modified. In 1961 they were completely rewritten and were approved by the Minister of Health in March 1962. There is always a tendency for the bylaws to be out of date before they have left the printers and out of stock shortly after. They define competently enough committees and the personnel thereof but they are not for the individual whose loyalty comes from some other source than a legal code.

This loyalty is a live quality of the many who work in the hospital. It would otherwise be impossible for the organisation to be so smooth. So much could go wrong; so little does. The fabric of the organisation is of course a century of experience, but this is not enough. The presence of authority, either visible or invisible, is necessary to maintain it. It is hard to pinpoint this authority much further. Visible authority is represented by the chairman or secretary of the Board, or by the medical superintendent or the lady superintendent but all these have a limited range of influence. They are the judges if things go wrong but they are not the sole architects if things go right. Of necessity they depute authority but for efficiency authority needs to be co-ordinated. This co-ordination with its smooth results is of elusive and mysterious origin. Perhaps the spirit of it lies in the summation of all the individual loyalties of the staff. Perhaps the claim of the sick is tapping all the time at the door of effort. Perhaps it is a quality not yet glimpsed.

Here then for present purposes the history of the hospital must rest and if, like all history, it has to be bound to artificial divisions of time then the present is appropriate enough. A century of hospital effort has passed and more than half a million patients have been treated. Through all the labours and the blunders and the triumphs of that century there has evolved not only a series of hospitals but a system of hospital services essential to the welfare of man in this day. Its present strength is rooted in its past evolution. Had it been the brilliant product of one modern mind its foundations might move. But it has been built on the basis of many lessons laboriously learned by common men and passed down the generations to become common knowledge.

So it is a phase and not a history that ends, for in 1962 the air is full of the echoes of history in the making. The older half of the hospital is to be replaced. Princess Margaret hospital is to be completed. Tuarangi, Jubilee, Essex and Teresa Green homes have a short future. The Board in 1954 bought 20 acres in Memorial avenue for a new hospital. The last of the old staff that presided over the birth of the special departments will shortly depart. The present Board is energetic and vigorous and loyally sponsors the new idea. Though it may be

an appropriate time to close the past it is a more appropriate time to open the future. Only one thing is as yet certain in that future—that it has inherited a fine tradition.

CHAPTER TWENTY-EIGHT

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Register of Appointments

THE QUALIFICATION FOR INCLUSION IN THE FOLLOWING LISTS is official appointment and either a reasonable period of service or a clear intention to serve. Members of the Board who resigned either before or immediately after their first meeting have been omitted. Other omissions have been the locums who covered the emergencies of sickness or holidays.

The symbols R and D refer to Resignations and Deaths. The register is complete up to April 1962 which is regarded as the present day and is abbreviated to P.D.

THE HOSPITAL BOARD

(The first controlling Board was the Christchurch Hospital and Charitable Aid Board. It operated from 1878 to 1885 when it was replaced by the North Canterbury Hospital Board which was the first such body to be elected by the ratepayers. This existed alongside a comparable Board known as the United Charitable Aid Board. In 1909 both these Boards were amalgamated as the North Canterbury Hospital and Charitable Aid Board. In 1920 this Board formed a Benevolent Subcommittee to control Charitable Aid and thus acquired its present (and previous) name of the North Canterbury Hospital Board.)

Mr H. Thomson	1878-1885	Mr C. T. Ick	1879-1881
Mr H. Allwright	1878-1883	Dr Turnbull	1878-1885
	and 1891-1892(D)	Mr J. G. Hawkes	1880-1885
Mr Montgomery	1878-1885	Mr J. Gapes	1881-1882
Mr G. Booth	1878-1880	Hon. E. C. J. Stevens	1881-1885
Mr J. E. Brown	1878-1880	Mr J. G. Ruddenklau	1882-1884

Dr Prins	1882-1885	Mr R. D. Thomas	1892-1893
Mr J. Joyce	1882-1884	and	1895-1898(R)
Mr S. R. Webb	1883-1884	Mr E. Mulcock	1892-1895
Mr C. P. Hulbert	1884-1885	Mr H. Y. Widdowson	1892-1894
Mr A. Chambers	1884-1885	Mr I. G. Murray	1894-1901
Mr W. White, Jnr.	1884-1885	Mr A. Wiffen	1894-1895
Mr R. Beetham	1885-1886	Mr G. Wallace	1895-1903(D)
Mr F. Bromley	1885-1886(R)	Dr F. McB. Stewart	1895-1897
Mr A. Chalmers	1885-1886	Mr I. A. Caygill	1895-1897
Mr J. Forrester	1885-1886	Mr G. R. Webb	1895-1896
	and 1894-1895	Mr F. E. Hunt	1895-1897
	and 1903-1904	Mr J. Dobson	1896-1906
Mr A. Ivory	1885-1886	Mr G. Payling	1896-1909(D)
Mr F. Jones	1885-1890	Mr C. F. Money	1897-1900
Mr W. Vincent	1885-1886	Mr J. Wolfe	1897-1900
Mr H. Lance	1885-1886		and 1901-1906
Mr C. Louisson	1885-1886		and 1907-1910
Mr J. McFarlane	1885-1886	Mr A. Marshall	1897-1898
Hon. R. Moore	1885-1886	Mr J. Hadfield	1897-1898
	and 1910-1925		and 1904-1907(R)
Mr H. N. Nalder	1885-1886	Mr W. Acton-Adams	1897-1902(R)
Mr H. W. Toomer	1885-1886	Mr G. H. McHaffie	1898-1904
Mr R. Westenra	1885-1892	Mr H. White	1898-1899
	and 1896-1898(R)	Mr W. Jacques	1898-1899
Mr W. White	1885-1889		and 1900-1903
Mr W. D. Wood	1885-1886	Mr E. Feldwick	1898-1900
	and 1887-1892		and 1903-1905
Mr D. Macmillan	1886-1891		and 1906-1907(R)
Mr W. Dunlop	1886-1892	Mr J. M. Douglas	1898-1900
	and 1893-1910	Mr H. H. Loughnan	1899-1905
Mr W. H. Hosking	1886-1887	Mr R. M. Taylor	1899-1900
Mr H. Prudhoe	1886-1892	Mr W. Dunlop	1900-1910
Mr J. C. Boys	1886-1889	Mr J. G. Murray	1900-1901
Mr R. H. Parish	1886-1895	Mr F. H. Davey	1900-1908
Mr W. Moor	1886-1895	Mr W. Rollitt	1900-1902
	and 1896-1897	Mr A. W. Rutherford	1900-1902
Mr R. Martindale	1886-1892(D)	Mr W. Radcliffe	1901-1902
Mr J. Tait	1887-1888	Mr W. Macmillan	1902-1908(R)
Mr H. Crooks	1889-1892		and 1912-1914
Mr H. Blackett	1889-1892		and 1915-1919(R)
Mr C. M. Gray	1888-1891	Mr D. D. McFarlane	1902-1906
	and 1893-1899	Mr C. H. Winney	1902-1904
Mr W. Langdon	1891-1893	Mr F. Horrell	1903-1932
Mr T. York	1892-1894	Mr Geo. Scott	1904-1908
	and 1900-1902		and 1913-1915(R)
Mr J. Rennie	1891-1894	Mr H. B. Sorensen	1904-1905
	and 1900-1902		and 1910-1923(D)
Mr R. H. Wood	1891-1896	Mr T. Gapes	1905-1908
Mr T. Cutler	1891-1893	Mr C. Allison	1905-1912
Mr J. Hamilton	1891-1904	Mr H. J. Horrell	1906-1908(R)
Mr W. Boag	1891-1894	Mr J. H. Davison	1906-1918
Mr H. W. Peryman	1892-1897	Mr C. D. Morris	1907-1910
		Mr J. Ingram	1908-1910

Mr J. Storry	1908-1910	Mr G. Armstrong	1923-1932
	and 1920-1922	Mr F. Rowell	1923-1926
Mr T. D. Boag	1908-1917		and 1929-1937(D)
	and 1919-1921	Mrs E. McCombs	1925-1934(R)
Mr T. N. Horsley	1908-1910	Rev. F. Rule	1925-1926
Mr J. M. Murray	1908-1911(R)	Mr L. B. Evans	1925-1947
Mr C. Cook	1908-1911	Mr P. M. Acton-Adams	1926-1928
Mr W. W. Tanner	1910-1917	Mr H. R. Davidson	1926-1934
Rev. W. L. Closs	1910-1912(R)	Mrs Teresa Green	1927-1959
Mrs W. Ensom	1911-1913	Sir H. T. D. Acland	1927-1947
Mrs J. H. Wilson	1910-1920	Dr P. S. Foster	1927-1938
Mr J. D. Hall	1910-1916		and 1947-1959
Mr J. Henderson	1910-1912	Mr J. Boyd	1928-1934
Mr D. Macmillan	1910-1947	Miss E. Cardale	1929-1930
Mr W. P. Spencer	1910-1944	Mr W. Anderson	1929-1930
Mr O. F. Clothier	1910-1911(R)	Mr P. W. Sharpe	1929-1930(R)
Mr E. O. Palmer	1910-1912	Mr J. S. Barnett	1930-1944
Mr A. H. Turnbull	1911-1915	Mrs J. S. Bean	1931-1950
Mr W. H. Montgomery	1911-1912(R)	Mr W. T. Foster	1931-1941
Mr H. L. Flower	1912-1913	Mr T. Thompson	1933-1934(D)
Mr Orton Bradley	1912-1920	Mr H. A. Bennett	1933-1947
Mr H. J. Otley	1912-1921		and 1950-1959
	and 1923-1938	Mrs I. Parlance	1934-1935
Mr T. Harrison	1912-1914		and 1937-1941
Mrs Christie	1912-1920	Mr R. A. Mould	1934-1953
Dr P. C. Fenwick	1912-1915	Mrs J. Mackay	1935-1938
	and 1922-1924(R)		and 1941-P.D.
Mr W. H. Cooper	1913-1919	Rev. F. T. Read	1935-1937(D)
Mr J. Ashley	1913-1915	Mr F. J. Monk	1935-1947
Mr I. Andrew	1914-1920(R)	Mr C. Flavell	1937-1947
Mr S. Andrew	1914-1925	Mr J. Heslop	1937-1941
Mr R. Evans	1915-1920	Mr H. E. Denton	1938-1941
Mr F. G. Norton	1915-1930		
Mrs Cath. Green	1915-1922(R)	Mrs R. M. Macfarlane	1938-1942
Mr H. Paterson	1916-1922		and 1950-1959
Mr W. Nicholls	1917-1920(D)	Mr R. E. Hope-Pearson	1938-1941
Mr W. Walter	1917-1947	Mrs J. N. Clarke	1941-1950
Mr M. Bethell	1918-1926	Miss M. McLean	1941-1947
Mr A. T. Smith	1919-1922		and 1956-1959
	and 1924-1936(R)	Mr R. T. Macmillan	1941-1946
Mrs A. Herbert	1917-1928(D)	Mr F. W. Freeman	1941-1944
Mr F. Burgoyne	1920-1921	Mr C. G. McKellar	1941-1953
Mr W. Armstrong	1920-1922	Mr T. Nuttall	1940-1941
Mr H. Holland	1921-1929(D)	Mrs W. G. Roberts	1941-1944
Mr W. E. Leadley	1921-1926	Mr V. C. Lawn	1944-1956
Mr D. McRae	1921-1922	Dr W. G. Rich	1944-1950
Rev. J. K. Archer	1921-1928	Mr H. Saunderclock	1944-1953
	and 1931-1938	Dr L. C. L. Averill	1944-P.D.
Mrs S. S. Page	1922-1923	Mr J. J. Brownlee	1947-1956
Mr J. W. Baty	1923-1924	Mr D. Macmillan (Dr)	1947-P.D.
Rev. Clyde Carr	1923-1928	Mr V. J. Corbett	1947-P.D.
Mrs W. G. Roberts	1923-1926	Mrs M. A. Ellen	1947-1950
	and 1941	Mr W. T. Lindsay	1947-1948(D)

Mr G. C. Warren	1947-1960(D)	Prof. A. J. Danks	1956-P.D.
Mr T. M. Ayers	1947-1959	Mr G. Oldham	1956-1960(R)
Mr A. J. Scott	1947-1950	Mr T. F. Carter	1956-1959
Mrs G. E. Boyd	1948-1959	and	1960-P.D.
Miss M. B. Howard	1950-1958(R)		1958-P.D.
Mr D. S. Dodds	1950-1953	Mr L. A. Bennett	1959-P.D.
Mr L. Christie	1950-1959	Dr I. C. Macintyre	1959-P.D.
Mr R. Bruce	1953-1959	Mr J. B. Hay	1959-P.D.
Mr E. P. Shier	1953-P.D.	Mr H. O. Hills	1959-P.D.
Mr W. Cole	1953-1956	Mr T. Smith	1959-P.D.
Mrs J. Mathison	1953-1959	Mr J. F. Roberts	1960-P.D.

CHAIRMAN OF BOARD

Mr H. Thomson	1878-1885	Mr W. Acton-Adams	1899-1901
Mr R. Beetham	1885-1886	Mr W. Jacques	1901-1902
Mr W. Vincent	1886	Mr W. Dunlop	1902-1903
Mr W. White	1886-1889	Mr G. Payling	1903-1909
Mr F. Jones	1889-1890	Mr J. Ingram	1909-1910
Mr R. Westenra	1890	Mr F. Horrell	1910-1920
Mr W. D. Wood	1890-1892	Mr H. J. Otley	1920-1921
Mr R. H. Wood	1892-1893	Mr H. B. Sorensen	1921-1923
Mr W. Moor	1893-1895	Mr H. J. Otley	1923-1938
Mr R. D. Thomas	1895-1898	Mr L. B. Evans	1938-1947
Mr C. M. Gray	1898-1899	Mr V. C. Lawn	1947-1956
Mr J. M. Douglas	1899	Dr L. C. L. Averill	1956-P.D.

SECRETARY, HOSPITAL BOARD

Mr C. E. March	1885	Mr A. Prentice	1937-1956
Mr W. Miller	1885-1909	Mr J. G. Laurensen	1956-P.D.
Mr T. C. Norris	1909-1912		
Mr W. S. Wharton	1912-1937	<i>Assistant Secretary</i>	
Mr W. A. Gudgeon	1937	Mr D. Horne	1947-P.D.

MEDICAL SUPERINTENDENT

(This position has been variously described as House Surgeon, Resident Surgeon, Medical Superintendent and since 1957 as Superintendent in Chief.)

Dr S. K. Stedman	1862-1863	Dr Hayes	1875
Dr Burrell Parkerson	1862-1863	Dr John Guthrie	1875-1877
Dr S. K. Stedman	1863-1864	Dr Mark	1878
Dr Downes	1864	Dr M. Chilton	1878-1879
Dr H. Prins	1864-1866	Mr Pridgeon	1879-1880
Dr L. Powell	1866-1868	Dr Davis	1880
Dr W. E. Phillips	1868-1869	Dr Mickle	1880-1881
Dr B. Parkerson, Jnr.	1869-1875	Dr R. M. Robinson	1881-1885
Dr D. Campbell	1875	Dr Doyle	1885
Dr R. B. Robinson	1875	Dr Westenra	1886-1887

Dr Guy D. Porter	1887	Dr P. S. Foster	1910-1911
Dr Bancroft	1887-1888	Dr F. L. Scott	1911-1916
Dr de Renzi	1888-1892	Dr Walter Fox	1916-1936
Dr Murray Aynsley	1892-1896	Dr A. D. Nelson	1936-1952
Dr Walter Fox	1896-1899	Dr T. Morton	1952-P.D.
Dr L. Crooke	1899-1910		

MATRON

(Variously known as Matron, Housekeeper, Lady Superintendent, and with the last appointment as Lady Superintendent in Chief.)

Mrs Bunting	1862-1864	Miss Maude	1893-1897
Mrs Harvey	1864-1865	Miss Johnson	1897-1898
Mrs Cook	1865-1873	Miss Payne	1898-1899
Mrs Pridgeon	1873-1880	Miss Ewart	1899-1908
Miss Esmond	1880-1881	Miss Thurston	1908-1916
Mrs Marriott	1881-1885	Miss Muir	1916-1935
Miss Paton	1885-1888	Miss Widdowson	1935-1952
Miss Boys	1888-1890	Mrs Chambers	1952-P.D.
Miss Steele	1890-1893		

SENIOR PATHOLOGIST

Dr G. M. Louisson	1907-1912	Dr D. T. Stewart	1949-P.D.
Dr A. B. Pearson	1912-1949		

SENIOR RADIOLOGIST

Dr L. Crooke	1898-1909	Dr W. Bates	1919-1921
Dr Inglis	1909-1915	Dr N. Guthrie	1921-1947
Mr Nelson	1915-1918	Dr G. L. Rolleston	1947-P.D.
Mr T. Sewell	1918-1919		

SENIOR RADIOTHERAPIST

Dr P. C. Fenwick	1924-1943	Dr A. J. Campbell	1943-P.D.
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SENIOR ANAESTHETIST

Dr Hazel Allison	1926-1944	Dr E. H. H. Taylor	1944-P.D.
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SENIOR DENTAL OFFICER

Mr E. Turrell	1894-1901	Mr Paulin	1919-1920
Mr A. L. Myers	1901-1913	Mr Rankin	1920-1925
Mr J. L. Saunders	1913-1914	Mr Ferguson	1925-1938
Mr Bell	1914-1915	Dr E. B. Reilly	1938-1947
Mr Rattray	1915-1919	Mr A. Russell	1947-P.D.

SENIOR DISPENSER

Mr Dalglish	1862	Mr McKinney	1897-1898
Mr W. R. Cooke	1862-1873	Mr R. Painter	1898-1912
Mr Pridgeon	1873-1880	Miss Gregory	1912-1916
Mr L. Hawke	1880-1887	Miss Dalley	1916-1917
Mr Hobden	1887-1890	Miss Rogers	1917-1925
Mr Papprill	1890-1895	Miss Laurenson	1925-1954
Mr Barrett	1895-1896	Miss Z. Sawers	1954-P.D.
Mr Bates	1896-1897		

SENIOR PHYSIOTHERAPIST

Mr Hilson	1893-1895	Sister Clark	1920-1922
Mr Hornibrook	1907-1912	Sister J. Irwin	1922-1941
Miss Allbrecht	1912		and 1944-1947
Miss Petersen	1912-1915	Miss J. Jennings	1941-1944
Mr Sarelius	1915-1917	Miss J. Adams	1947-1951
Miss Burberry and		Miss J. Derbidge	1951
Miss Dixon	1917-1918		and 1953-P.D.
Sister Smith	1918-1920	Miss M. L. K. Sams	1951-1953

DIRECTOR OUTPATIENT SERVICES

Dr W. I. Paterson 1960-P.D.

DIRECTOR DEPARTMENT OF PSYCHIATRIC MEDICINE

Dr J. R. Dobson 1961-P.D.

SENIOR ENGINEER

Mr G. W. Loughton	1889-1932	Mr A. Wilson	1935-1962
Mr W. Drummond	1932-1935	Mr J. D. Jones	1962-P.D.

SUPERINTENDENT OF WORKS

Mr W. Harrop	1917-1937	Mr C. R. McCallister	1956-1958
Mr R. A. Rose	1937-1956	Mr D. F. Prestney	1958-P.D.

OFFICER IN CHARGE OF STORES

Mr A. Russell	1912-1939	Mr F. T. Hogsden	1948-1955
Mr G. Hollingworth	1939-1948	Mr A. J. Cameron	1955-P.D.

THE HONORARY CONSULTING STAFF

(The Consulting Staff throughout the history of the hospital has had various meanings. It was once synonymous with the Visiting Staff and at a later date it was composed of those who had agreed to

serve in an emergency. It began to acquire a new dignity in 1928 when the main prerequisites for appointment were recognised as merit and length of service. At present the appointments are made by the full Board and are restricted to those members of the visiting staff who have had a minimum of twelve years' service.)

PHYSICIANS

Dr Wm. Irving	1931
Dr Hand Newton	1946
Dr J. Marks	1946
Dr W. Aitken	1949
Dr A. B. Pearson	1949
Dr R. H. Quentin Baxter	1952
Dr A. C. Thomson	1953
Dr M. K. Gray	1958
Dr F. O. Bennett	1958
Dr M. H. Aiken	1960

SURGEONS

Dr T. L. Crooke	1928
Sir H. T. D. Acland	1929
Dr A. C. Sandston	1929
Dr T. A. MacGibbon	1931
Dr J. F. Duncan	1932
Dr T. Mill	1932

Dr Walter Fox	1935
Dr H. L. Widdowson	1936
Dr J. Guthrie	1936
Dr P. C. Fenwick	1943
Dr H. Wales	1946
Mr P. S. Foster	1946
Dr N. Guthrie	1949
Dr W. G. Scannell	1956
Mr W. M. Cotter	1956
Mr J. Leslie Will	1956
Dr W. Mark Brown	1957
Mr L. A. Bennett	1957
Dr M. Robertson	1958
Mr D. Macmillan	1958
Mr E. R. Reay	1959
Mr D. G. Radcliffe	1959
Dr Caroline Stenhouse	1960
Mr J. K. Davidson	1960
Mr D. McK. Dickson	1961

CHAPTER TWENTY-NINE

63/20

Index of Chronology

- 1850 The first four ships.
1851 The Rev. O. Mathias's house becomes first Lyttelton hospital.
1854 Customs house becomes second Lyttelton hospital.
1859 Christchurch Public Hospital Bill passed.
1861 Christchurch Hospital Ordinance passed.
1862 Christchurch Public Hospital opened.
1863 New Lyttelton hospital opened.
1864 Hospital and Charitable Aid Bill passed.
1869 Lyttelton Hospital closed.
1876 Abolition of Provincial Government.
Christchurch Local Board of Health gazetted.
Medical School at Canterbury College gazetted (invalid).
Wards 4 and 5 erected.
Christchurch hospital fenced.
1878 Erection Ward 6.
Inauguration Destitute Patients Fund (No. 1).
Appointment first Hospital and Charitable Aid Board.
1884 Hospital connected with city sewer.
1885 First elected Hospital and Charitable Aid Board.
First trained nurse Christchurch hospital.
1886 Erection Ward 3 (second ward 3).
Operating theatre built (2nd).
1887 New Kitchen built (2nd).
Hospital Lady Visitors' Association formed.
1889 Boiler house built.
1891 Formal training of nurses commenced.

- 1895 Commission of Enquiry on Hospital Board.
First Nurses' Home erected.
Destitute Patients' Fund established (2nd).
- 1897 Hyman Marks wards (7 and 8) built.
- 1898 First X-ray established Christchurch hospital.
- 1899 Electric light installed in hospital.
First pathology laboratory established in dispensary.
- 1900 Founding of Health Department.
Laundry built (2nd).
- 1902 Hospital operating theatre built (3rd).
Plague hospital erected at Bottle Lake.
- 1904 Medical Superintendent's house built.
System of medical case notes established.
- 1907 Extension of Nurses' old home.
- 1908 Fire in ward 8.
- 1909 First hospital pharmacopeia.
- 1910 First meeting N.C. Hospital and Charitable Aid Board.
Elbow taps in wards.
Erection of wards 9 and 10.
- 1911 New wing of Nurses' Home opened.
- 1912 General office of Board built in Administration Block.
Position of Head Porter created.
- 1913 Dental department established.
Steam heating of wards.
- 1914 Hospital corridor and Administration Block completed.
Second ward 3 demolished.
Erection wards 12 and 13 (stage 1).
- 1915 Pathology department removed to first floor Administration Block.
- 1917 Original ward 1 demolished.
Chalmers Block (wards 1, 2, and 3) opened.
Works department formed.
Venereal Disease Outpatients commenced.
- 1918 The influenza epidemic.
Premises of present X-ray and physiotherapy erected.
Military orthopaedic unit established.
Second storey built on laundry.
- 1919 New morgue erected.
Telephone bureau established at hospital.

- 1920 Occupational therapy introduced by H.L.V.A.
- 1921 Radiotherapy department established.
- 1922 Orthopaedic department formed.
The Annexe built.
Two theatres built on present site.
- 1924 First electrocardiograph.
- 1925 Hospital Boards' Association formed.
Nurses' superannuation introduced.
- 1926 Erection Ward 11.
Erection top storey Administration Block.
First dietitian appointed.
- 1927 Hospital Chapel opened.
- 1929 Cafeteria opened.
- 1930 First full time chaplain.
- 1931 Building of Nurses' new Home.
- 1932 Formation Medical Staff Executive.
Formation Appointments Advisory Committee.
- 1933 Canterbury Medical Library formed.
- 1934 Consultation Clinic established.
- 1936 Hospital bakery established.
Loud speaker system throughout hospital.
- 1937 Formation of branch Medical Faculty.
- 1938 Old military premises become wards 14 and 15.
First postgraduate course held.
- 1939 Free hospital beds.
- 1941 Free outpatients.
Three storeys added to Nurses' Home.
- 1942 St Andrew's Manse site purchased.
Extensions to wards 12 and 13.
First contract with Commercial Cleaners.
- 1943 Marshland Road vegetable garden purchased.
- 1944 St Andrew's specialist outpatients opened (first stage).
Animal farm established at Marshlands.
- 1945 Laundry built (3rd).
Friends of the Hospital established.
- 1946 Free pathology and radiology services.
- 1947 Christchurch Hospital Nurses' Association formed.
- 1948 Present theatre block doubled and modernised.
First use of radioactive iodine.

- Commencement of nurses' study day per week.
- Hospital bakery closed.
- 1949 Photographic unit formed (date approx.).
- 1950 The Lodge (36 Hereford Street) purchased.
- 1951 Workshops erected in St Asaph Street.
- 1952 Extended St Andrew's outpatients opened.
- First hanging screens fitted in ward 15.
- First medico-social worker appointed.
- 1954 The Royal visit.
- Department of Anaesthesia formed.
- Purchase of 20 acres in Memorial Avenue.
- 1956 Visitors' waiting room completed.
- New offices established in Superintendent's residence.
- 1957 Theratron unit established.
- New bulk store erected.
- Recovery ward opened.
- 1958 Nurses' Recreation Hall opened.
- N.Z. Hospital Visiting Staff Association formed.
- Records Department acquire new premises.
- Admitting and Discharge Office established.
- 1959 Three chapels appeal launched.
- 1960 Canterbury Medical Research Foundation established.
- Library transferred to old sewing room.
- 1961 Director of outpatients appointed.
- Pharmacy transferred to ward 5.
- Department of Psychiatric Medicine established.
- Emergency and Accident Ward approved.
- Spinal Injury Unit approved.
- Ward 11 modified to become the genito-urinary unit.
- 1962 Centenary of Christchurch Hospital.

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He was appointed to the honorary part-time staff of Christchurch Hospital in 1935, later becoming an Anaesthetist and an Assistant Physician (both honorary appointments). He retired in 1958 as a Senior Visiting Physician. He is now a member of the Board's Honorary Consulting Staff and Medical Officer for the Homes for the Aged under the Board's control.

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